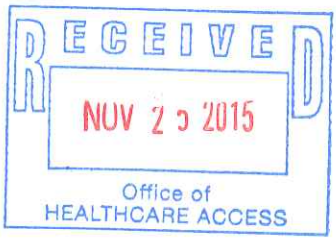
November 25, 2015

Via Hand Delivery



Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: CON Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc.

Dear Ms. Martone,

Enclosed please find the original CON application for the transfer of ownership and control from Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

We are pleased to be submitting this application to your office because it offers an outstanding opportunity for both entities to secure quality health care in the future for all of our patients. We anticipate that patients will have greater access to health care as we collaborate and share our resources. We also expect operational efficiencies in the new affiliated system that will benefit both entities by creating a secure financial base for the provision of health care in the future.

We look forward to any way that we may be useful in the process that lays ahead, and thank you, in advance, for your consideration of this application. If you have any questions, please do not hesitate to call any one of us.

Respectfully submitted,

Saint Mary's Health System, Inc.
and Saint Mary's Hospital, Inc.

By: _____
Chad W. Wable
President and CEO

Trinity Health – New England, Inc.

By: _____
Christopher M. Dadlez
President and CEO

Trinity Health

By: _____
D. Scott Nordlund
Executive V.P.

Checklist

Instructions:

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

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

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

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

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

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original in a 3-ring binder.

☒ The following have also been submitted on a CD or USB drive

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

For OHCA Use Only:

Docket No.: 15-32045-CON **Check No.:** 39410
OHCA Verified by: SO **Date:** 11/25/15

Customer	A/C #	Billing Period
ST. MARY'S HOSPITAL	75401	10/01/15-10/31/15

RepublicanAmerican

389 Meadow Street, Waterbury, CT 06722
Phone: 203-574-3636 Fax: 203-573-0090 Toll Free: 800-992-3232
E-mail: advbilling@rep-am.com

PAYMENT TERMS	30 DAYS
TOTAL AMOUNT DUE	$ 410.64

Fed EIN 06-0581760 * Please See Reverse Side for Pub Index

DATE	AD # / INV #	CUST ORDER #	PUB*	DESCRIPTION	SIZE	BILLED UNITS	TIMES RUN	RATE	BILLED AMOUNT
				PREVIOUS BALANCE					$0.00
10/22/15-10/24/15	RA0695501 / INV001055518		RA	NOTICE Under Connecticut General Statutes Sec. 19a-638,	1x	59.000	3	$2.3200	$410.64
				CURRENT AMOUNT DUE					$410.64
				TOTAL AMOUNT DUE					$410.64

NOTICE
Under Connecticut General Statutes Sec. 19a-638, as amended by Public Act 15-146 Saint Mary's Health System, Inc., a Connecticut non-stock corporation, and its affiliated entities, are proposing to join the Regional Health System created by Trinity Health Corporation, an Indiana nonprofit corporation, and Saint Francis Care, Inc., a Connecticut non-stock corporation. As a result of this proposed transaction, Saint Mary's Health System, Inc. including Saint Mary's Hospital, Inc. (Saint Mary's) will become a member of the new Regional Health System. The corporate organization and governance of Saint Mary's will be revised to be consistent with the organizational and governance structure of other New England Regional Health Ministry facilities. Saint Mary's Hospital, Inc. and all of its affiliates and related entities will remain at their current locations. There are no capital expenditures for this proposal. Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Saint Francis Care, Inc. and Trinity Health will file a Certificate of Need application for this project with the Department of Public Health through the Office of Health Care Access. The addresses of the organizations are as follows:

Saint Mary's Health System, Inc. and
Saint Mary's Hospital, Inc.
56 Franklin Street
Waterbury, CT 06706

Saint Francis Care, Inc.
114 Woodland St.
Hartford, CT 06105

Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152
RA 10/22,23,24,2015

RECEIVED
NOV 11 2015
CHAD WABLE

Past due balance accrues finance charge of 1.5% per month

All charges include any applicable Connecticut State sales tax

REMITTANCE ADVICE - PLEASE RETURN WITH PAYMENT	REMITTANCE ADDRESS	REPUBLICAN AMERICAN PO BOX 2090 WATERBURY, CT 06722-2090

CUSTOMER	A/C #	BILLING PERIOD	TOTAL AMOUNT DUE	AMOUNT REMITTED
ST. MARY'S HOSPITAL	75401	10/01/15-10/31/15	$ 410.64	

CREDIT CARD #	
EXPIRATION DATE	
SIGNATURE	

ST. MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY CT 06706

CHECK #	

RepublicanAmerican

389 Meadow Street • Waterbury, CT 06702 • 1-800-992-3232

Classified Advertising Proof

Account Number: 75401
Order Number: RA0695501

ann ferraro
ST. MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY, CT 06706
203-709-6000

Title: Republican-American | **Class:** L-Legal -Public Notice 019
Start date: 10/22/2015 | **Stop date:** 10/24/2015 |
Insertions: 3

Title: Rep-Am.com | **Class:** L-Legal -Public Notice 019
Start date: 10/22/2015 | **Stop date:** 10/24/2015 |
Insertions: 3

NOTICE

Under Connecticut General Statutes Sec. 19a-638, as amended by Public Act 15-146 Saint Mary's Health System, Inc., a Connecticut non-stock corporation, and its affiliated entities, are proposing to join the Regional Health System created by Trinity Health Corporation, an Indiana nonprofit corporation, and Saint Francis Care, Inc., a Connecticut non-stock corporation. As a result of this proposed transaction, Saint Mary's Health System, Inc. including Saint Mary's Hospital, Inc. (Saint Mary's) will become a member of the new Regional Health System. The corporate organization and governance of Saint Mary's will be revised to be consistent with the organizational and governance structure of other New England Regional Health Ministry facilities. Saint Mary's Hospital, Inc. and all of its affiliates and related entities will remain at their current locations. There are no capital expenditures for this proposal. Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc. Saint Francis Care, Inc. and Trinity Health will file a Certificate of Need application for this project with the Department of Public Health through the Office of Health Care Access. The addresses of the organizations are as follows:

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114 Woodland St.
Hartford, CT 06105

Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152
RA 10/22,23,24, 2015

Total Order Price: $410.64

Please call or send an email by 3pm to approve or to make changes.
(No call back will result in your ad running as it appears on this proof.)

Advertisements placed on CTJobs.com, AfterCollege.com and Recruitment Networks run for 30 days

Salesperson: Deborah | **Printed on:** 10/21/2015
Telephone: 203-574-3636 ext 1162 | **Fax:** 203-754-0644

SAINT MARYS HOSPITAL
SMH RECEIVING DOCK 99 UNION STREET
WATERBURY, CT 06706

Vendor #16676
TREASURER STATE OF CT OAK ST WKRS CO

Nº 394110

P.O. NUMBER	INVOICE DATE	INVOICE NUMBER	INVOICE AMOUNT	DISCOUNT AMOUNT	NET AMOUNT
	11/20/2015	CON FILING	500.00	.00	500.00
		Totals:	500.00	.00	500.00

PAYMENT AMT: 500.00

Saint Mary's HOSPITAL

WEBSTER BANK - STMH - A/P
WATERBURY, CT 06706

Nº 394110

51-7010/2111

DATE
11/23/2015

CHECK AMOUNT
500.00

Five Hundred And 00/100 Dollars**********

PAY TO THE ORDER OF TREASURER STATE OF CONNECTICUT

TREASURER STATE OF CONNECTICUT
55 ELM ST
HARTFORD, CT 06106

TWO SIGNATURES REQUIRED IF OVER $50,000.00

Saint Mary's HOSPITAL

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Trinity Health – New England, Inc.
to become the Sole Member of Saint Mary's Hospital, Inc.
Certificate of Need Application

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2	List of Healthcare Transformation Taskforce	
3	Transfer Agreement with Saint Francis Care and Trinity Health Corporation	
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State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- General Information
- Affidavit
- Abbreviated Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

All Supplemental Forms

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

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

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

General Information

Main Site*

MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
N/A	Inpatient – 004041760 Outpatient- 004025060	Hospital	Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

STREET & NUMBER	
56 Franklin Street	
TOWN	**ZIP CODE**
Waterbury, CT	06706

*For additional sites

Project Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
N/A	IP - OP-	Hospital	Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

56 Franklin Street	
TOWN	**ZIP CODE**
Waterbury, CT	06706

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)

STREET & NUMBER	
TOWN	**ZIP CODE**

Chief Executive

NAME	TITLE
Christopher Dadlez	President and CEO Trinity Health – New England, Inc.

STREET & NUMBER		
114 Woodland Street		
TOWN	STATE	ZIP CODE
Hartford	CT	06105

TELEPHONE	FAX	E-MAIL ADDRESS
860-714-5541	860-714-7920	cdadlez@stfranciscare.org

Title of Attachment:

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	See **Exhibit 10**

Does the Applicant have non-profit status? If yes, attach documentation.	YES ☒ NO ☐	See **Exhibit 23**
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☒	Other: _____
Applicant's Fiscal Year (mm/dd)	Start 10/01/14 End 09/30/15	

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

Contact Information			
NAME		TITLE	
R. Christopher Hartley		Senior Vice President Planning, Business Development & Government Relations, Trinity Health - New England, Inc.	
STREET & NUMBER			
114 Woodland Street			
TOWN		STATE	ZIP CODE
Hartford		CT	06105
TELEPHONE		FAX	E-MAIL ADDRESS
860-714-5573		860-714-8093	chartley@stfranciscare.org
RELATIONSHIP TO APPLICANT	Employee		

Contact Information			
NAME		TITLE	
Robert Anthony		General Counsel	
STREET & NUMBER			
56 Franklin Street			
TOWN		STATE	ZIP CODE
Waterbury		CT	06706
TELEPHONE		FAX	E-MAIL ADDRESS
203-709-6093		203-709-3238	BAnthony@Stmh.org
RELATIONSHIP TO APPLICANT	Attorney		

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

Prepared by			
NAME		TITLE	
Joseph Connolly		Chief Experience Officer and VP of Administration	
STREET & NUMBER			
56 Franklin Street			
TOWN		STATE	ZIP CODE
Waterbury		**CT**	**06706**
TELEPHONE		FAX	E-MAIL ADDRESS
203-709-6093		203-709-3238	jconnolly@stmh.org
RELATIONSHIP TO APPLICANT	Employee		

AFFIDAVIT

Applicant: **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **Chad Wable, President and Chief Executive Officer** of **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** being duly sworn, depose and state that **Saint Mary's Health System, Inc.** and **Saint Mary Hospital, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 11/23/15 Date

Subscribed and sworn to before me on 11/23/15

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

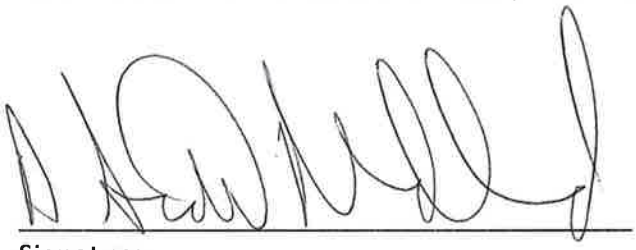
My commission expires: VICTORIA CIPRIANO NOTARY PUBLIC MY COMMISSION EXPIRES FEB. 28, 2017

AFFIDAVIT

Applicant: **Trinity Health**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **D. Scott Nordlund, Executive Vice President** of **Trinity Health** being duly sworn, depose and state that **Trinity Health's** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature

11·25·2015

Date

Subscribed and sworn to before me on 11-25-2015

Claudia A. Crane

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

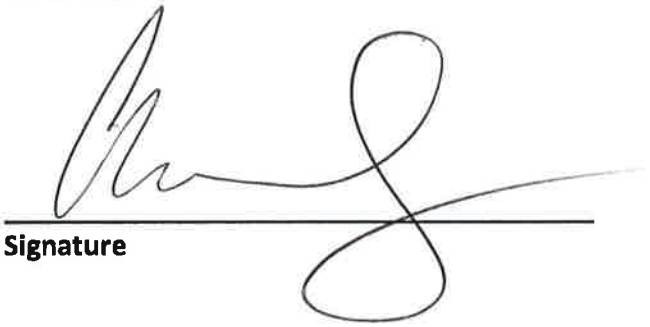
Claudia A. Crane, Notary Public
State of Michigan, County of Oakland,
My Commission Expires 11/17/2019
Acting in the County of _____

AFFIDAVIT

Applicant: **Trinity Health-New England, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, Christopher Dadlez, President and Chief Executive Officer of Trinity Health-New England, Inc., being duly sworn, depose and state that **Trinity Health-New England, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature 11-20-15 **Date**

Subscribed and sworn to before me on 11-20-15

Joseanne Christina Lubin-Scafuredi, Esq.

Notary Public/Commissioner of Superior Court

~~**My commission expires:**~~ _____

Executive Summary

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

If the proposed transaction described in this application is approved, Trinity Health-New England, Inc. (previously Saint Francis *Care*, Inc.), which, effective on October 1, 2015, became the new Trinity Health Regional Health Ministry (NE-RHM) will become the sole corporate member of Saint Mary's Hospital, Inc. (SMH) through a transfer agreement and the NE-RHM will serve as Saint Mary's Hospital parent. It is anticipated that Saint Mary's Health System will be dissolved, restructured or merged into Saint Mary's Hospital, Inc. (collectively referred to herein as "SMHS"). The key elements of this transaction include the following changes:

- Trinity Health, including the NE-RHM, is sponsored by Catholic Health Ministries, an entity established by the Catholic Church to oversee the healing ministry and Catholic identity of Trinity Health.
- SMHS and its related entities will join the NE-RHM in a manner consistent with other organizations within the NE-RHM. Please see **Exhibit 4** for the proposed NE-RHM organization chart. SMHS will continue to meet the service needs of its population within its defined primary service area.
- The proposed transaction is between not-for-profit entities. Although no cash purchase price is contemplated, if the proposed transaction is approved, Trinity Health through the NE-RHM will make substantial operational and financial commitments to SMHS and the communities it serves including:
  - Preservation and support of SMHS's not-for-profit mission and Catholic identity;
  - Commitment of at least $100 million dollars in capital investments to benefit SMHS and its related entities over a five-year period and an additional $20 million if certain performance metrics are achieved;
  - Access to NE-RHM and Trinity Health system services to reduce SMHS's operating costs and promote efficiency;
  - Development of a plan to adequately fund SMHS's pension liabilities; and
  - Improved access to capital and debt financing.
- The NE-RHM Board of Directors will include two members from the SMHS community that will be appointed to the NE-RHM.
- For three years following the effective date on which SMHS joins NE-RHM, in addition to any required external approvals, the existing SMHS Board must approve any terminations or material reduction of existing clinical services.
- To facilitate continuity of care in the SMHS service area, the medical staff admitting privileges and medical staff bylaws of SMHS and its related entities will remain in place.
- SMHS' medical education, research, community support and participation in governmental healthcare programs will not be changed as a result of this transaction.

- SMHS will remain a nonprofit, tax-exempt charitable organization and will honor all existing donor restrictions associated with philanthropic donations made to SMH and its related entities.

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

Project Description

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

The Parties

The parties involved are Saint Mary's Health System, Inc. ("SMHS"), including Saint Mary's Hospital, Inc., Trinity Health – New England, Inc. (previously Saint Francis *Care*), which effective October 1, 2015 joined Trinity Health and became the new Reginal Health Ministry in New England ("NE-RHM") and Trinity Health. All three entities operate as non-profit, 501(c)(3) corporations. As noted under The Proposal section below, it is anticipated that Saint Mary's Health System will be dissolved, restructured or merged with and into Saint Mary's Hospital.

Saint Mary's Health System, which includes Saint Mary's Hospital (Reference **Exhibit S1** for the current Saint Mary's Health System organization chart) is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community. NE-RHM is a regional provider of healthcare through Saint Francis Hospital and Medical Center and its numerous related facilities in the greater Hartford, Connecticut area. Trinity Health is a one of the largest national Catholic healthcare providers. This application is submitted to enable Saint Mary's Hospital and its related entities to join the NE-RHM.

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. (collectively referred to herein as "SMHS")

SMHS is a leading regional healthcare provider anchored by Saint Mary's Hospital (SMH), a Catholic, not-for-profit, acute care, community teaching hospital that has served Greater Waterbury since 1907. Licensed for 347 beds, SMH is designated as a Level II Trauma Center and operates one of the busiest emergency departments in the state. Its service area includes 16 towns and 2 boroughs in the greater Waterbury area. Its mission is to provide excellent healthcare in a spiritually enriched environment to improve the health of its community. SMH offers award-winning cardiac care and is the region's leading provider of surgical services. Surgical subspecialties include general, neurospine, orthopedics, cardiothoracic, breast, ear, nose and throat, eye, podiatry, urology, vascular and plastic surgery. SMH has established residency programs in internal medicine, surgery and general

dentistry with the Yale School of Medicine. SMHS has been recognized by the U.S. News & World Report as Top Performing in Heart Failure Care (2015); named a Top Performer by the Joint Commission two years in a row in the areas of heart attack, heart failure, pneumonia and surgical care; achieved seven Gold Awards from the American Heart Association/American College of Cardiology; one of the first hospitals to participate in the ACC's Patient Navigator Program to improve outcomes of heart failure patients; listed as one of the top 100 hospitals in value recognized by Cleverley & Associates three years in a row; and #1 hospital in Connecticut based on the CMS Value Based Purchasing Program. See **Exhibit 1** for SMHS's Awards and Accolades.

Trinity Health-New England, Inc. ("NE-RHM")

NE-RHM is the parent company of numerous health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford[1]. Saint Francis Hospital and Medical Center is the third largest hospital in Connecticut, and the largest Catholic hospital in New England. It is licensed for 617 general hospital beds and 65 bassinettes, and provides a full range of inpatient, outpatient and ancillary services. The service area includes Hartford and its surrounding towns. On August 31, 2015, NE-RHM received approval from the Office of Health Care Access in Docket No. 15-31979-CON to join Trinity Health. The transfer of NE-RHM to Trinity Health and the formation of a New England Regional Health Ministry became effective on October 1, 2015. If this application is approved, SMHS will be joining Trinity Health through NE-RHM, creating a formal partnership between two Connecticut Catholic health systems within a larger network of health systems and hospitals in New England.

Trinity Health

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 21 states from coast to coast with 88 hospitals, and 126 continuing care facilities, home health and hospice programs, and PACE center locations that provide more than 2.5 million visits annually.

The organization was formed in May 2013, when Trinity Health and Catholic Health East officially came together to strengthen their shared mission, increase excellence in care and advance transformative efforts with our unified voice. With annual operating revenues of about $15.8 billion and assets of about $20.4 billion, the new organization returns about $1 billion to its communities annually in the form of charity care and other community benefit programs.

Trinity Health employs more than 95,000 full-time employees, including 3,900 employed physicians. Committed to those who are poor and underserved in its communities, Trinity

1 NE-RHM is also the parent company of Mercy Hospital located in Springfield, Massachusetts.

Health is known for its focus on the country's aging population. As a single, unified ministry, the organization is the innovator of Senior Emergency Departments, the largest not-for-profit provider of home health care services — ranked by number of visits — in the nation, as well as the nation's leading provider of PACE (Program of All Inclusive Care for the Elderly) based on the number of available programs. Trinity Health is also focused on transitioning from success in the traditional fee for service based healthcare economy, to a people-centered population health organization. To ensure continued long-term sustainability while completing that transition, Trinity Health has developed and is implementing a strategic plan to enhance the scale and integration of the system in core markets.

Trinity Health has created an internal development team, charged with the growth and strategic positioning of the system. Two of Trinity Health's key growth initiatives aim to extend and strengthen the Catholic healthcare mission of the organization through alignment with other organizations, and to expand the system footprint to create an integrated accountable care organization ("ACO") in every one of its markets. The development team works with the executive management team and governance to identify growth priorities in acute care, outpatient, and population health areas to build out the continuum of service to achieve these goals. The development team takes a disciplined approach to structuring partnerships with identified organizations which have shared values and vision that help to accomplish key goals within markets.

Trinity Health has a breadth of experience in the use of best practices and quality data to improve service delivery. Dr. Richard Gilfillan, President and CEO of Trinity Health, currently chairs the Health Care Transformation Task Force, a group of providers, payers, purchasers and patient groups dedicated to the alignment of private and public sector efforts to advance value-based purchasing. Please refer to **Exhibit 2** for a list of members of this task force. The purpose of this group is to forge a common perspective and set of recommendations on different policy approaches that encourage sharing best practices from both clinical and financial perspectives and that change the way health care providers deliver and are reimbursed for care delivery. Through such sharing, the Health Care Transformation Task Force will help the country move toward a system focused on delivering quality care at a reduced cost. The chances of success of this value-based payment initiative are also reinforced by the track record Dr. Gilfillan has earned through his leadership of the Federal Center for Medicare and Medicaid Innovation, which oversaw the creation of accountable care organizations and bundled payments for Medicare.

The Proposal

The proposal is an organizational change request to allow Saint Mary' Hospital and related entities to become a part of NE-RHM. This will be effectuated by a Transfer Agreement (**Exhibit 3**) between Saint Mary's Health System, Inc., (which includes Saint Mary's Hospital, Inc.), Trinity Health-New England, Inc. (also known as NE-RHM) and Trinity Health (collectively "the Parties"). The NE-RHM will become the sole corporate member of Saint Mary's Hospital and Saint Mary's Hospital will be a direct subsidiary of NE-RHM. It is

anticipated that Saint Mary's Health System will be dissolved, restructured or merged with and into Saint Mary's Hospital. The proposed corporate structure is set forth in **Exhibit 4**.

There is no change in clinical services requested, nor is there any change of location involved with any of the clinical services now being offered by SMHS as a direct result of this proposal. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

All assets of SMHS will remain assets and properties of SMHS. All charitable gifts to SMHS will remain a part of Saint Mary's Hospital Foundation (a separate 501c3 organization) and will be used as the donor directed.

Trinity Health and NE-RHM have agreed to ensure the expenditure of One Hundred Million Dollars ($100,000,000) for capital expenditures at SMHS over the first five years following the effective date of the Transaction. If SMHS reaches a specified operating cash flow margin in the 3rd year following the effective date of the Transfer Agreement, an additional ten million ($10,000,000) dollars of committed capital will be available to SMHS in the 4th year following the effective date and similarly if in the 4th year following the effective date of the Transfer Agreement, SMHS reaches a specified operating cash flow margin, an additional ten million ($10,000,000) dollars of committed capital will be available to SMHS in the 5th year following the effective date. This committed capital will be available to support the capital needs of SMHS and its related entities, including strategic growth and infrastructure development for SMHS's integrated delivery system, to expand and upgrade SMHS's health care facilities, equipment and services provided by SMHS, and to support SMHS community health/population management initiatives as well as strategic growth, which includes physician network development.

Two members of the NE-RHM Board of Directors will be appointed by Trinity Health for a period of three years, with eligibility for re-appointment. These members will be from the SMHS community. Chad Wable will continue to serve as the President and CEO of SMHS and will also have a substantial and meaningful regional oversight/governing role in NE-RHM. SMHS will continue its Catholic identity and will operate in a manner consistent with the Ethical and Religious Directives for Health Care Services as promulgated by the United States Conference of Catholic Bishops.

As a result of this Transfer Agreement, the Parties intend to:

- improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area, including SMHS's Waterbury service area;

- enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to safety and satisfaction;

- reduce the costs of healthcare in the NE-RHM Service Area, including SMHS's

Waterbury service area;

- support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

Equipment/Service Locations and the Geographic Area the Proposal Will Serve

This proposal does not involve any new equipment, nor does it involve a change of location for any of the services currently being offered by SMHS or its related entities. For current locations of the health services that are provided by SMHS, please see the answer to Question No. 8, below. Similarly, the NE-RHM will not be adding or deleting services or any equipment as a result of this CON application, and its geographic area will not change as a result of this CON application. For the specific details of the current service locations and geographic area served by NE-RHM, please see OHCA Docket No. 15-31979.

Need for the Proposal in the Community

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. SMHS's motto is "Exceptional care. Every day. Every Patient." In order to maintain this high standard in the future, SMHS recognized a number of years ago that it would need to partner with another healthcare provider in order to maintain the quality it currently provides. This need to partner with another health care institution is driven by many factors. Changes in health care delivery, which became part of federal law with the passage of the 2010 Patient Protection and Affordable Care Act ("PPACA"), as well as reform in federal health policy and reimbursement have been a catalyst in propelling SMHS to seek new models of providing care. Other factors that have been intensifying and are contributing to the need for this proposal include:

- the increased cost associated with quality improvements,
- physician partnerships,
- clinical service redesign,
- electronic medical records development,
- strategic alignments to form an integrated organization,
- an aging infrastructure and the need to provide the health services the community in Waterbury requires, as reflected in the Community Needs Assessment (**Exhibit 6**).

There is also a need, along with the subsequent cost, to upgrade medical records to the standard required as a result of the PPACA. Furthermore, the range of services health care providers are required to offer has shifted from services healing the sick and injured to a focus on preventing illness and promoting wellness. At the same time that these external pressures have emerged, the population in Waterbury is rising, and the median age of the population is older than the State average (44 vs. 40). An older population utilizes more health services, in general, than a younger population. See answer to Question 8(a), Table

1, below.

The new healthcare technologies that have emerged in the last ten years, along with the high price tag of implementing some of this technology, have stretched the budgets of all health care systems, including SMHS. The sheer number of patients needing to be included in the system of electronic medical records has soared, and with it, the cost. The physical plant which houses Saint Mary's Hospital was built in 1907, and exceeds 1 million square feet. While renovations and remodeling have occurred over the years, as well as newer additions, the physical plant is in need of upgrades in order to continue providing exceptional care, as well as to accommodate the technology used for today's best practice medicine.

In anticipation of the many changes in the healthcare industry resulting from the passage of the PPACA, SMHS undertook a revision of their strategic planning process to create a vision and foundation for success for SMHS in the healthcare system of the future, a system that would be fundamentally different from the fee for service approach to healthcare delivery. The plan is continuously upgraded to match current goals. The 2016-2020 Strategic Plan is attached as **Exhibit 5**. The shift in emphasis from fee for service to accountable care organizations and population health means revamping the way health care is delivered. The emphasis on wellness means a shift in emphasis from inpatient hospital care to care that can be delivered in an outpatient setting, and a different set of objectives. The resulting strategy is directly related to the Community Needs Assessment (attached as **Exhibit 6)**, developed in collaboration with a number of local providers and stakeholders and published in September of 2013 which identified the major health needs of the Waterbury community.

In order to achieve all of these goals, SMHS needs a stronger financial base. It has a responsibility to fund its employee pension plan and ensure access to capital in order to invest in the shift to a new way of delivering health care.

While strategically positioning itself for the challenges and opportunities posed by the Affordable Care Act and other changes in the healthcare industry, SMHS, like many other healthcare systems, determined that its mission and goals could best be effectuated by partnering with another healthcare system with a complementary mission and similar goals. SMHS recognized many years ago that it would be prudent to become partners with another hospital or health care system in order to take advantage of the strength that would result from consolidation. Sharing clinical expertise, best practice management, and the value that can be derived from joint purchasing in larger volume led SMHS to continually look for a partner that would match SMHS commitment to providing quality care to all the people in its service area, while being compatible with its Catholic tradition and principles. Over the last ten years, SMHS actively looked for another hospital to be its partner. But healthcare changed dramatically in the past few years. During the last year, SMHS contemplated joining a regional/national health system in order to help SMHS achieve a successful implementation of its Strategic Plan. In the creation of the new regional health ministry, SMHS found that Trinity Health and NE-RHM had a strategic plan

very similar to its own, and Trinity Health has the experience to help both Connecticut systems to achieve their goals. NE-RHM and Trinity Health are more closely aligned with SMHS than any previous potential partner. They all share a common vision, similar values, philosophy and mission, and together will strengthen the Catholic healthcare tradition in the NE-RHM service area. To achieve its vision of Best*Care* for a Lifetime, NE-RHM has already begun its transformation to a virtually integrated care delivery network that provides care through a combination of aligned providers, which has been developed through both alliances and select acquisitions. To further its transformation to an integrated delivery system, NE-RHM has redesigned its organizational structure into a strategic portfolio composed of service lines and support platforms, all of which serve as conduits for the delivery of care across the system. (Please see **Exhibit 7** for an outline of NE-RHM service lines and support platforms.) The focus of this structure and these aligned providers is to meet the Affordable Care Act Triple Aim objectives of improving population health, enhancing the patient care experience and controlling costs while maintaining a positive financial margin. This transformation will facilitate the transition by NE-RHM from a provider of clinical services to a manager of the health of populations.

Christopher M. Dadlez, FACHE, the President and CEO of Trinity Health-New England, Inc., which will be the parent of Saint Mary's, recently published an article entitled, "Population Health Management: The Intersection of Concept and Reality" that further articulates the future of healthcare and the movement of NE-RHM towards population management (see **Exhibit 14**). As Mr. Dadlez notes, population management will be achieved through a clinically integrated network of alliances, aligning primary, secondary and tertiary services with community hospitals to promote the delivery of "the right care in the right place for the right value." NE-RHM also will leverage its support platforms to achieve economies of scale where possible to lower the overall cost of care to the community (see **Exhibit 8**). This mirrors SMHS's goal of exceptional care, for every patient, every day, while lowering the cost of that care.

The benefits to SMHS's from this partnership with NE-RHM and Trinity Health are as follows:

- To have access to the resources of a large system at both the regional (NE-RHM) and national (Trinity Health) levels which will allow SMHS to continue to provide quality health care services in the greater Waterbury area and be able to expand those services within its service area by making them more accessible to a greater number of people;
- To have the resources necessary to help develop more preventive and primary care services in the greater Waterbury area so that patients in the SMHS's service area stay healthy, including the resources to implement the programs identified in the 2014 Community Health Needs Assessment;
- To meet the demands of the 2010 Patient Protection and Affordable Care Act which requires an emphasis on value rather than volume in terms of reimbursement for health care services;

- To create efficiencies so that health resources are not wasted, which will also enable more patients to be served;
- To have readily available access to capital and financing for that capital at favorable interest rates; and
- To develop a plan to adequately fund SMHS's pension plan obligations.

Trinity Health-New England, Inc. ("NE-RHM")

NE-RHM set forth the reasons for joining Trinity Health in its CON application located in Office of Health Care Access Docket No. 15-31979-CON. The reasons Trinity Health – New England, Inc. sought to partner with Trinity Health are very similar to the reasoning of SMHS.

NE-RHM*'s* Board leadership created a special ad hoc Advisory Committee to review potential partners that would enable NE-RHM to meet the strategic goals outlined in their CON application. A number of potential strategic partners were considered before NE-RHM selected Trinity Health.

NE-RHM determined that Trinity Health was the ideal affiliation partner in that it satisfies the strategic, mission, financial and governance goals established by NE-RHM as part of its selection process. More particularly, Trinity Health enhances NE-RHM's ability to fulfill its strategic vision in that:

- Trinity Health is one of the largest Catholic health systems in the country and an organization that has a mission and strategic vision essentially identical to those of NE-RHM;
- The transaction preserved and supported NE-RHM*'s* not-for-profit status, mission, values and Catholic identity;
- Access to Trinity Health system services provides operational efficiencies for NE-RHM;
- Access to national best practices and expertise enhances NE-RHM, ability to pursue existing and future programs related to population health, emerging models and initiatives for the delivery of healthcare, and health information technology;
- Trinity Health is a national system with a AA- credit rating which grants NE-RHM access to capital and provides an opportunity to lower NE-RHM, cost of debt financing; and
- Trinity Health agreed to (i) develop a plan to enable NE-RHM to satisfy long-term pension liabilities, and (ii) provide commitments for capital which will ensure investments of at least $275 million over the next five years.
- Trinity Health is committed to maintaining a local and regional presence.

The result of this evaluation was a decision by NE-RHM to file a CON application with the Office of Health Care Access to become part of the Trinity Health Care system. The transfer of NE-RHM to Trinity Health created the new Trinity Health – New England, Inc. ("NE-

RHM"). (See OHCA approval of Docket Number 15-31979 CON on 8/31/15). The new organization is continuing its pursuit of other like-minded health system partners to add to its regional ministry. As a part of this pursuit, the NE-RHM responded to a Request for Proposal from SMHS.

If this proposed transaction is approved, SMHS will serve as an important part of this regional health ministry. The addition of SMHS to the NE-RHM will enhance its ability to pursue local partnerships and affiliations across the continuum of care, evaluate additional acute care growth opportunities across the region, and work to develop broader population health and risk-bearing capabilities appropriate to the evolving healthcare markets.

The proposed transaction will facilitate the continuation of SMHS's 108+ year commitment to providing health care services to patients in the communities it serves in the dynamic and changing environment of health care delivery. SMHS will build on this foundation and its own long-standing commitment to quality and clinical excellence. The NE-RHM is well recognized for its commitment to quality care as evidenced by the extensive list of awards and recognitions. (See **Exhibit 9**). The Waterbury community served by SMHS will benefit greatly from this proposal.

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

In February 2015 SMHS hired Hanlon, Hammond Camp, LLC ("H2C") as its consultant to guide them on the affiliation process. H2C reached out to a select group of not-for-profit hospitals that had or would likely soon have a presence in the Connecticut market. In early March 2015, H2C sent confidentiality agreements and a transmittal letter/term sheet to three organizations. The organizations included Trinity Health and two Connecticut hospital networks. By late March, all of the organizations executed the confidentiality agreement and responded with either a proposal or a revised term sheet. Another hospital system (#4) reached out to H2C and expressed interest in SMHS. A confidentiality agreement was executed and a transmittal letter was sent to them in late March 2015. However, in early April 2015, Hospital System #4 withdrew from the process. All three remaining proposals were strong and competitive.

Trinity Health and NE-RHM met with the SMHS's Board-appointed Taskforce ("the Taskforce") on March 24, 2015. In late April and early May 2015, the Taskforce met with the three original potential partners. In late May 2015, several SMHS Taskforce members conducted a site visit to Mercy Medical Center in Springfield, Massachusetts, which is affiliated with Trinity Health.

In early June 2015, one of the Connecticut hospital networks (#3) was eliminated from consideration for a full member substitution due to their inability to fully meet the guiding principles for the Ethical and Religious Directives ("ERD"). The SMHS Taskforce remained very interested in clinical affiliations and other possible partnerships models with Trinity Health and NE-RHM.

In June 2015, a group of physician leaders from SMHS met with physician leaders from the second Connecticut Health Network (#2). A similar meeting was held with NE-RHM and Trinity Health physician leaders.

Throughout June 2015, H2C continued discussions with Connecticut Health Network (#2) and Trinity Health and NE-RHM (#1). By early July Trinity Health, NE-RHM and SMHS discussions were moving forward, and in mid-July, due diligence began and SMHS opened up the full data room to Trinity Health and NE-RHM, and commenced a 30-day exclusivity period with Trinity Health and NE-RHM. H2C presented the SMHS Board with a high level comparison of offers. The SMHS Taskforce and Board had access to the following documents for Trinity Health and NE-RHM.

- A Taskforce Issues List was created with Trinity and the other potential partner, (Health Network #2) where the two entities were compared on the following topics: Strategic, Pension, Financial, Canonical/ERDs, Capital Expenditures, Governance Rights, Medical Community, Clinically Integrated Network/Population Health, Physician Recruitment/Talent, Reverse Due Diligence, Transactional Risks, Mission/Cultural Fit and Clinical Capabilities. A second detailed Comparison of Offers was created.

- Additional information on a number of hospitals in Connecticut was prepared for purposes of comparison, including the status of pension funds of the entities being considered as a partner.

- Based on the recommendation of the SMHS Board Taskforce, the full board voted on September 13, 2015 to approve a Transfer Agreement with Trinity Health and NE-RHM to become part of the Trinity New England Regional Health Ministry. On September 18, 2015 the three parties signed the Transfer Agreement.

A significant difference between Trinity Health and NE-RHM and Connecticut Hospital Network #2 is that SMHS's pension plan would remain a church plan in Trinity Health's network. In Network #2, SMHS's pension plan would become an ERISA plan, which required additional logistical and administrative costs. Trinity Health also has a broader network of clinical services than Network #2, and can offer more technical expertise than all of the other proposals that were considered. As a national Catholic healthcare network, Trinity Health's mission and values were more closely aligned with SMHS's than the other networks. After evaluating the proposals, the Taskforce recommended continuing discussions with Trinity Health and NE-RHM.

The SMHS Board of Directors meeting minutes documenting the vote are included. (See **Exhibit 10**).

3. Provide the following information:

a. utilizing OHCA Table 1, list all services to be added, terminated or modified, their

physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

No changes in existing services are included in this Certificate of Need Application. Hence, this table is not applicable.

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

Please refer to **Exhibit 11.** Also refer to the answer to the question 8(a) below, including Figure 1.

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

No new licenses are being sought in this CON application.

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

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

Please refer to **Exhibit 12** for a copy of all the existing Department of Public Health licenses.

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

SMHS:
Chad Wable, FACHE President and Chief Executive Officer
Ralph W. Becker, MBA Vice President & Chief Financial Officer
Charles Flinn, FACHE, Vice President & Chief Operating Officer

Trinity Health - New England, Inc.:
Christopher Dadlez, FACHE, President and Chief Executive Officer
John Rodis, M.D., Chief Operating Officer
David Bittner, Chief Financial Officer

Trinity Health
Richard J. Gilfillan, M.D., MBA, President and Chief Executive Officer
Benjamin R. Carter, CPA, FHFMA, Executive Vice President and Chief Financial Officer/Treasurer
James Richard O'Connell, Executive Vice President – East Group
D. Scott Nordlund, Executive Vice President

Please refer to **Exhibit 13** for copy of all the Curricula Vita related to this project.

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

This question is not applicable as this CON is not requesting new services. However, attached are two relevant articles pertaining to organizational change.

Exhibit 14a: Dadlez, Christopher. "Population Health Management: The Intersection of Concept and Reality", Frontiers of Health Services Management 30:4
Exhibit 14b: Gilfillan, MD, Richard J. "Today's Transformation Mission-Opportunity Abounds to Bring More People Better Care", Catholic Health Association of the United States; September-October 2015.

d. letters of support for the proposal;

See **Exhibit 15** for letters of support received to date for this Certificate of Need.

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

This question is not applicable since this Certificate of Need is an organizational change request not a change in clinical services.

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

Please refer to **Exhibit 3** for a copy of the Transfer Agreement and other documents related to this proposed organizational change.

Public Need and Access to Care

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

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

The proposed project is consistent with all existing policies and standards in regulations

adopted by the Connecticut Department of Public Health. All of the existing hospitals involved in this CON application as well as their affiliated health care providers are in compliance with existing laws. As a result of this application, the existing health services now offered by SMHS, either at the hospital or off-site will not change.

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

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

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

The Transfer Agreement between SMHS, NE-RHM and Trinity Health is consistent with the *Statewide Health Care Facilities and Services Plan* (the "Plan") published by the Connecticut Department of Public Health's Office of Health Care Access ("OHCA") in October of 2012 and supplemented in 2014. The Transfer Agreement between the three parties is clearly aligned with the premise of the Plan. Section 1.4 of the Guiding Principles of the Plan states:

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;

- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state. (Plan at, p. 2.)

As the Plan makes clear, as of 2012, OHCA was aware that mergers, affiliations and acquisitions were part of a transformation that had begun as the State's health care system responded to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5) By 2014, the supplement to the Plan listed the corporate affiliations that have already occurred in Connecticut. Becoming part of a larger health care system such as Trinity Health will aid SMHS in developing economies of scale when purchasing supplies and services, and will also improve access to capital. These factors, in turn will allow SMHS to improve the quality of care that is required by the 2010 Patient Protection and Affordable Care Act ("PPACA").

As OHCA has recognized in the Plan, the strategic, financial and quality of care advantages associated with the affiliation or mergers of hospitals and health care providers are key drivers in today's health care environment. Connecticut hospitals are pursuing affiliation arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow SMHS to make needed capital improvements, invest in new technology and continue to be a safety net provider in the Greater Waterbury region.

By entering into the proposed Transfer Agreement with Trinity Health, SMHS and the NE-RHM will be able to work actively towards expanding cost control initiatives in community-based settings and remain a lower-cost, high-quality provider for the patients in its service area.

As part of the NE-RHM, SMHS will be able to improve its technology and the overall standard of care for its patients. The Plan recognizes that a health information technology exchange ("HITE") "makes it possible for health care providers to better manage patient care through secure use and sharing of health information." (Plan at p. 14, Sec. 2.2.1). The NE-RHM will provide access to capital and the Trinity Health intercompany loan program, if necessary, to develop a HITE and electronic health records ("EHRs"). Paper records will be replaced by EHRs to report patients' diagnostic data. Opportunities to regionalize the health care delivery system in the greater Waterbury area will be enhanced, building upon existing initiatives. The size of Trinity Health and the NE-RHM will provide SMHS with regional and national scale, leverage and resources to meet the health care reform requirements of the PPACA.

The PPACA requires hospitals to improve quality of care delivered to patients through a variety of means such as improving infection control programs and reducing preventable readmissions for certain conditions. (Plan at pp. 12-13, Sec. 2.1.2, 2.1.3, 2.1.4., 2.1.4.2 and 2.1.4.3). Trinity Health, as a national provider of health care, is aware of these requirements and has the ability to share best practices among its member hospitals, and has already provided evidence at its existing facilities of improving infection control programs and reducing readmissions. This proposal promotes Population Health Management which is a system that emphasizes health promotion and the delivery of preventive and medically necessary care. Population Health Management promotes collaboration among providers and the development of a continuum of care where providers are more closely aligned and work in a cohesive environment. Trinity Health has experience with 88 hospitals and provides an environment that SMHS's physicians and other providers across the continuum of care can utilize to provide access to evidence-based practices. These practices will improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

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

a. identify the target patient population to be served;

SMHS has a service area that consists of 16 towns and two boroughs. The primary service area ("PSA") consists of Naugatuck, Prospect, Waterbury and Wolcott. The secondary service area ("SSA") includes the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plymouth, Southbury, Southington, Thomaston, Watertown and Woodbury. The two boroughs in the secondary service area are Terryville (part of Plymouth) and Plantsville (part of Southington). Please see Figure 1 for a map of the service area. The 16 towns and 2 boroughs have historically been the towns SMHS has included in its service area. These towns accounted for 93.5% of the Hospital's volume in FY2015.

Figure 1: Saint Mary's Health System, Inc. Service Area

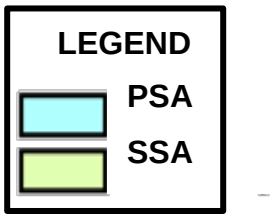


Table 1 provides a summary of the population of the service area from 2000 projected to 2020. The City of Waterbury (a PSA for the Hospital) is projected to experience a 4.9% increase in population from 2010 to 2020. A population increase of 5.5% is projected for the 12 town secondary service area. (See **Table 1** below.)

Waterbury is the largest municipality in the service area. In 2010, it accounted for 66% of the population in the primary service area and 32% of the population in the total service area.

Table 1: Total Population 2000 – 2020

Town	2000	2010	2020
Naugatuck	30,989	31,746	32,877
Prospect	8,707	9,282	9,864
Waterbury	107,271	109,941	115,128
Wolcott	15,215	16,446	17,821
Primary Service Area	**162,182**	**167,415**	**175,690**
Beacon Falls	5,246	5,909	6,648
Bethlehem	3,422	3,595	3,711
Cheshire	28,543	29,200	29,120
Middlebury	6,451	7,390	8,471
Morris	2,301	2,461	2,460
Oxford	9,821	12,192	14,714
Plymouth	11,634	12,213	12,789
Southbury	18,567	19,690	20,480
Southington	39,728	42,491	45,136
Thomaston	7,503	7,873	8,112
Watertown	21,661	22,522	23,020
Woodbury	9,198	9,909	10,395
Secondary Service Area	**164,075**	**175,445**	**185,056**
Total Service Area	**326,257**	**342,860**	**360,746**

Source: Connecticut Economic Resource Center, Inc. (CERC, 2014). Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

Tables 2 and 3 describe the age distribution in the primary and secondary service areas by town. The age distribution of the service areas is also compared to that of the state. SMHS's total service area has a median age of 44 compared to the state's median age of 40 (CERC, 2014). The difference in age is one of many contributing factors that lead to increased healthcare utilization.

Table 2: Age Distribution Primary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Naugatuck	6.3%	15.0%	8.4%	35.3%	21.5%	13.4%
Prospect	4.3%	16.5%	8.8%	32.7%	23.1%	14.5%
Waterbury	7.3%	18.0%	10.2%	34.4%	17.4%	12.6%
Wolcott	3.3%	19.3%	8.2%	32.2%	21.4%	15.7%
PSA	**6.6%**	**17.5%**	**9.6%**	**34.2%**	**18.9%**	**13.2%**
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC, 2014

Table 3: Age Distribution Secondary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Beacon Falls	5.3%	18.1%	7.7%	33.9%	22.8%	12.1%
Bethlehem	3.4%	15.2%	9.1%	22.9%	31.2%	18.1%
Cheshire	4.3%	19.1%	9.1%	32.3%	21.0%	14.2%
Middlebury	3.7%	18.8%	5.7%	30.5%	23.4%	17.8%
Morris	3.5%	18.5%	6.3%	31.5%	28.1%	12.2%
Oxford	5.9%	18.6%	7.0%	30.4%	25.4%	12.7%
Plymouth	4.6%	16.7%	9.0%	33.2%	23.7%	12.7%
Southbury	3.8%	17.3%	5.7%	23.3%	22.8%	27.1%
Southington	5.2%	16.9%	6.1%	32.0%	22.1%	17.7%
Thomaston	3.5%	16.1%	8.1%	36.6%	21.5%	14.2%
Watertown	5.2%	16.9%	7.6%	31.4%	22.3%	16.5%
Woodbury	4.0%	16.4%	6.4%	27.5%	29.0%	16.7%
SSA	4.6%	17.5%	7.2%	30.7%	23.1%	16.9%
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC, 2014. Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

Table 4 presents socio-economic data for the primary and secondary service area in comparison to the State. The data for the total service area reveals a diverse population ranging from urban to suburban to rural. While some of the communities are composed of an older, more affluent population, Waterbury is an economically distressed community with 20% of its population below the poverty level. The significant levels of poverty are reflected in the patient mix treated at the Hospital. In Fiscal Year 2015 Year to Date (October 1, 2013 – June 30, 2015), 43.9% of patients discharged from the Hospital were Medicaid recipients.

Central Waterbury has been designated by the Health Resources and Services Administration as a Health Professional Shortage Area as well as a Medically Underserved Area and Medically Underserved Population. The Hospital serves

as a safety net hospital to this region. This proposal provides the necessary cost savings opportunities to ensure that health care services will remain available to the vulnerable population in the Hospital's service area. The proposal will ensure a more secure financial future so that the Hospital can continue to provide essential health services to the community. It is premature to have completed detailed projections of operational savings, however, an annual savings of at least 1% of SMHS's revenues, or about $3M, are anticipated based on historical savings generated after acquisition by Trinity Health's. We would expect that approximately 50% of this savings will be realized within the first 12-15 months of the closing of the proposed transaction. In each future year, it is expected that the same $3M in cost savings resulting from the transaction will continue to impact favorably on SMHS as compared to its current operations.

Table 4: Socio/Economic Data

Town	Poverty Rate*	Household Income*	Unemployment rate**	Median Age*
Primary Service Area				
Naugatuck	8.6%	$62,574	9.4%	39
Prospect	3.2%	$95,325	6.7%	44
Waterbury	21.9%	$40,867	12.5%	35
Wolcott	3.4%	$80,655	7.8%	44
Secondary Service Area				
Beacon Falls	3.8%	$79,207	7.0%	39
Bethlehem	4.4%	$80,884	5.8%	50
Cheshire	2.8%	$110,587	6.2%	41
Middlebury	2.6%	$97,996	6.6%	44
Morris	5.6%	$89,688	5.9%	45
Oxford	4.5%	$107,308	6.4%	45
Plymouth	6.7%	$73,603	8.9%	41
Southbury	6.4%	$67,195	6.6%	50
Southington	3.6%	$78,668	6.4%	44
Thomaston	2.7%	$67,426,	7.8%	43
Watertown	3.4%	$80.899	7.7%	44
Woodbury	4.6%	$80,167	5.9%	48
Connecticut	**10.0%**	**$69,519**	**7.8%**	**40**

**2012*

*** 2013*

Source: CREC 2014. Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

After the CON proposal is implemented, the existing populations that the Hospital serves will continue to have access to the same services that SMHS

currently provides.

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

The Hospital provides a comprehensive range of services that meets the needs of its target population. The services are listed below:

Cardiovascular services

- Diagnostic catheterization
- Interventional Cardiology- Angioplasty
- Pacemaker Implantation
- Cardiac surgery
- Medical Cardiology
- Telemetry Monitoring
- Cardiovascular unit for post interventional patients
- Electrophysiology

Surgical services

- General surgery
- Robotic surgery
- Bariatric surgery
- Neurosurgery
- Orthopedic surgery
- Other surgical specialties including colorectal, gynecology, urology, gastroenterology, otolaryngology, podiatry, thoracic, vascular, breast and oncology
- Ambulatory surgery (on hospital main campus as well as off-site at Naugatuck Valley Surgical Center)

Medical services

- General Adult Medicine
- Pulmonary
- Neurology
- Oncology/Hematology
- Endocrinology
- Critical Care Medicine
- Other medical specialties covering nephrology, gynecology, urology, gastroenterology, rheumatology

Women and Infant services

- Obstetrics
- Neonatology (Level 2 NICU)

Behavioral Health

- Adult and adolescent inpatient Behavioral Health services
- Outpatient Mental Health Clinic and Substance Abuse Treatment Center

Emergency Department

- Emergency Department including a Level 2 Trauma Center
- Designated a Primary Stroke Center (by Connecticut Department of Public Health)

Imaging Services

- CT Scanning
- Digital mammography
- DEXA bone density scanning
- Nuclear Medicine
- Ultrasound
- MRI
- X-ray
- PET/CT (through the Harold Leever Regional Cancer Center)

Interventional Radiology

- Angiography
- Biopsies
- Stent Placement

Breast Care

- Stereotactic breast biopsies
- Breast ultrasound

Other Outpatient Programs

- Three Urgent Care Centers located in Naugatuck, Waterbury and Wolcott
- Accredited Sleep Disorders Center located in Wolcott and Waterbury
- Physical and Occupational Therapy
- Cardiac and Pulmonary Rehabilitation
- Pulmonary Function Testing
- Endoscopy Services
- Dental Clinic
- Family Health Center
- Cardiac Diagnostic Testing
    - Nuclear Stress Testing
    - Echocardiography
    - EKG
    - Holter monitoring/event and loop recording
- Laboratory Services

Services are provided on the Hospital's main campus as well as outpatient locations throughout the service area.

SMHS currently leases space on the main campus to two organizations to provide inpatient services. Inpatient pediatric services are provided by

Connecticut Children's Medical Center ("CCMC") and inpatient hospice services are provided by VITAS, a national provider of hospice and palliative care.

Saint Mary's Physician Partners, LLC (an Accountable Care Organization) is a clinically integrated physician network that provides services to beneficiaries of certain insurance programs and facilitates the coordination and cooperation among healthcare providers to improve quality.

The Hospital offers health care services under its license at the following locations:

- Naugatuck Valley Surgical Center, 160 Robbins St., Waterbury;
- Naugatuck Urgent Care Center, 799 New Haven Rd., Naugatuck;
- Wolcott Urgent Care Center, 503 Wolcott Rd., Wolcott;
- West Main Urgent Care Center, 1312 West Main St., Waterbury;
- Cardiovascular Diagnostic Center, 1320 West Main St., Waterbury;
- Occupational Health & Diagnostic Center, 1312 West Main St., Waterbury;
- Saint Mary's Outpatient Center, 1981 East Main St., Waterbury;
- Saint Mary's Outpatient Behavioral Health Services, 100 Jefferson Sq., Waterbury;
- Saint Mary's Blood Draws:
    1) 133 Scovill St., Waterbury;
    2) 1981 East Main St., Waterbury;
    3) Union Square, Southbury; and
    4) 70 Hemingway Park Rd., Waterbury.

- Franklin Medical Group, P.C., a physician group of approximately 88 physicians and 46 midlevel providers have 17 office locations in the Greater Waterbury area including:
    1) 133 Scovill St., Waterbury; Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary;
    2) 95 Scovill St., Waterbury; Specialties: Internal Medicine and Pediatrics,
    3) FMG Behavioral Healthcare Outpatient Services; 100 Jefferson Square, Waterbury; Specialty: Outpatient Behavioral Health Services;
    4) 1981 East Main St., Waterbury; Specialty: Internal Medicine;
    5) 202 Water St., Naugatuck; Specialty: Internal Medicine;
    6) FMG Primary Care Partners, 166 Waterbury Rd., Prospect; Specialties: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery and Breast Surgery;
    7) FMG Wolcott Internal Medicine, 503 Wolcott Rd., First Floor, Wolcott; Specialty: Internal Medicine;
    8) FMG Breast and Oncology Center, 33 Bullet Hill Rd., Suite 214, Southbury; Specialties: General Surgery and Breast Surgery;
    9) 1320 West Main St., Waterbury; Specialties: Cardiology, Pulmonary (Sleep Medicine);

10) 140 Grandview Ave., Suite 4, Waterbury; Specialty: Gastroenterology;
11) 590 Middlebury Rd., Suite A, Middlebury; Specialty: General Surgery;
12) 1389 West Main St., Waterbury; Specialty: General Surgery;
13) 70 Heminway Park Rd., Watertown; Specialty: Internal Medicine; and
14) 56 Franklin St., 2nd Floor, Waterbury; Specialty: Cardiology.
15) Digestive Disease Center of CT; 60 Westwood Avenue, Waterbury, CT 06708
16) Naugatuck Internal Medicine; 1177 New Heaven Road, Naugatuck, CT 06770
17) Polokoff Breast Care; 900 Main Street South, Southbury, CT 06488

- Radiology services are offered at Diagnostic Imaging of Southbury, LLC, 385 Main St., Southbury;
- Cancer Services are offered at the Harold Leever Regional Cancer Center, 1075 Chase Pkwy. Waterbury. This facility, owned 50% by Saint Mary's Hospital and 50% by Waterbury Hospital.
- Heart services are offered under the auspices of the Heart Center of Greater Waterbury, Inc., 1075 Chase Pkwy., Waterbury; and are provided at Saint Mary's Hospital and Waterbury Hospital. This entity, owned 50% by each hospital, is not part of this CON application.
- Diagnostic services are offered at Naugatuck Valley MRI, LLC in 4 locations within the service area.

All health care services, including those provided by CCMC and VITAS, will continue to be offered at their current locations.

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

This question is not applicable. Changes to services or equipment are not included in this proposal.

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

There are no new locations in this CON proposal. SMHS is located in Waterbury.

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

Please see response to Question 8.a., above.

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

SMHS Catholic mission is to serve all patients regardless of race, ethnicity, handicap, religion, income level, or ability to pay. This will not change if the CON

proposal is approved. For additional information please see response to Supplemental CON Application Form, Transfer of Ownership/Sale of Hospital, Question 4.j.

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

No immediate changes to the clinical services provided by SMHS are planned at this time as a direct result of this proposal. The NE-RHM will provide additional support for continuing quality improvement of the clinical services provided at SMHS, and at this time no changes in clinical services are being proposed. Going forward, if this proposal is approved, as proposed changes are identified, the NE-RHM will comply with the Certificate of Need laws and will file the appropriate documents with, and seek the approval of, the Office of Health Care Access as required by law.

h. explain how access to care will be affected;

This Certificate of Need Application is to sustain and strengthen the services at SMHS ensuring that access to services is not only maintained, but expanded in order to meet evolving community need. Reduction of services is not part of this proposal. Also, please refer to response to 9a below.

i. discuss any alternative proposals that were considered.

Please refer to Question 2.

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

9. Describe how the proposal will:

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

SMHS will have access to the NE-RHM's experts in all clinical service lines and support platforms, and its service delivery approach and systems will be enhanced with the goal that programming at SMHS mirror the performance of like programs at NE-RHM. Particular focus will be on the Cancer, Joint Replacement and Cardiology service lines.

In order to improve the quality of health care services in the Waterbury service area, and to contribute to the future of outstanding health care in general, SMHS

offers graduate medical education programs in:

- Internal Medicine Residency
- Dental Residency
- General Residency
- Yale Medicine – Pediatrics Residency

SMHS has been affiliated with the Yale University School of Medicine for over 40 years. Nearly all of SMHS faculty are Yale faculty members. SMHS has produced physicians of the highest caliber, including academic and clinical general internists, medical subspecialists, and both clinical and laboratory investigators.

The Internal Medicine Residency includes rotations in Cardiology, ICU, Night Float, Ambulatory, Elective, Emergency Dept., General Wards and the Family Health Center. The chairman of the Department of Medicine at SMHS and Program Director of the Internal Medicine Residency Program is Jason R. Ouellette, MD, FACP. Dr. Ouellette is also an Assistant Clinical professor at Yale University School of Medicine.

The Dental Residency Program involves a one-year General Practice Residency (GPR) which has been fully accredited by the American Dental Association since 1951. SMHS also participates in the Dental Postdoctoral Application Support Service (PASS) which is one of only five such programs in Connecticut, offering participants a wide range of clinical experience.

The general Surgery Residency Program is an independent training program, graduating two Chief residents per year. Dr. J. Alexander Palesty, MD, FACS is the Program Director while Dr. Philip Corvo, MD, FACS is the Chairman of the Stanley J. Dudrick Department of Surgery. The training program in surgery is a 6-year program. Residents are exposed to pre-operative, operative as well as post-operative and non-operative care of patients in all of the components of general surgery.

SMHS is one of the four hospital teaching sites which hosts the Yale Medicine/Pediatrics Residency Program. Combined with the other three residency programs offered with Yale, SMHS has established its commitment to quality health care through the education of our future physicians.

In addition, whenever possible, SMHS's physicians and staff will be involved in the educational and health care innovation efforts of the NE-RHM. The following are examples of the educational and health care innovations efforts of NE-RHM that present opportunities for SMHS's physicians and staff:

- The NE-RHM also has a long standing commitment to the education of medical, dental, nursing and allied health professionals. This educational focus emphasizes quality and application of cutting edge technology to the treatment of patients. In addition, through its Institute for Primary Care

Innovation Simulation Studio, students, residents, fellows and current practicing physicians are exposed to the latest developments in health care delivery. The constant influx of bright, questioning minds encourages innovation and applications of the latest techniques. In addition, organizations that participate in the training of the next generation of providers provide better care and attract a higher caliber of providers. The NE-RHM's focus on population management and health outcomes is also regularly stressed as part of its various teaching endeavors.

- The NE-RHM sponsors medical, surgical, dental, nursing and allied health educational programs because it recognizes that education is fundamental to maintaining excellence in patient care and to ensuring the continued institutional development of new resources for the care of its patients. Continuing medical education activities are integrally related to undergraduate and graduate educational programs. Together, they have an important impact on the medical staff, promoting the delivery of medical care consistent with contemporary national standards and early introduction of new advances in medical and surgical care. The current availability of house staff at the NE-RHM plays an important role in the provision of high-quality care, and these individuals serve as an important reservoir of future attending physicians in the NE-RHM. Graduate medical education establishes an attractive base of hospital affiliation for those completing their training and helps to ensure the future quality of care by developing a cadre of well-qualified practicing physicians affiliated with the institution.

- The NE-RHM maintains independent, hospital-based fellowships and residency programs and also participates in the University of Connecticut School of Medicine Integrated Residency Training Programs. The NE-RHM's residency programs and all of the University of Connecticut's Integrated Residency Training Programs have been approved by the Accreditation Council on Graduate Medical Education.

- Accreditation Council on Dental Education. The NE-RHM is also a member of the Council on Teaching Hospitals and the Association of American Medical Colleges. A list of residencies offered at the NE-RHM through the University of Connecticut School of Medicine is included in **Exhibit 16.**

- The NE-RHM offers programs for various allied health professions and disciplines to rotate through various departments of the NE-RHM. These allied health professionals include medical technologists, radiological technologists, physical therapists, respiratory therapists and technicians, physician assistants, pharmacists and nurse practitioners.

In addition, the NE-RHM has successfully deployed many quality tools and best practices to help achieve an optimal patient and family experience through a patient-centered continuum of comprehensive quality services.

The NE-RHM believes that what can be measured can be improved. Accordingly, The NE-RHM*'s* service lines integrate a variety of clinical data bases as registries for standardized bench marking and quality performance assessment. The NE-RHM has received a wide range of quality accolades as a result of these efforts. (Refer to **Exhibit 9**). SMHS also has received a wide range of quality accolades. Please refer to **Exhibit 1**.

By joining the NE-RHM, SMHS can participate more directly in this effort. The chances of success of this value-based payment initiative are also reinforced by the track record Dr. Gilfillan has earned through his leadership of the Federal Center for Medicare and Medicaid Innovation, which oversaw the creation of accountable care organizations and bundled payments for Medicare.

SMHS sees its decision to join the NE-RHM as the best plan to address the continued reduction in federal and state funding while preserving its 108+ year legacy of providing health care services to all residents in its service area regardless of their ability to pay.

Trinity Health is intently focused on the delivery of high-value Triple Aim outcomes that improve the health of those it serves, reduce the per capita cost of delivering care, and that improve the quality of care and satisfaction of our patients. The infographic to the right highlights Trinity Health's view of what the organization needs to become to thrive in the future environment. The Trinity Health strategic plan focuses on building a people-centered health system to achieve the vision of becoming a mission-driven, innovative health organization that will become a national leader in improving the health of our communities and each person we serve as a trusted health partner for life.

Trinity Health's PEOPLE-Centered 2020 strategy is focused on its population health journey to improve the health of its communities and the experience of care for patients. Trinity Health's strategy is to build a people-centered health system in which the people it serves are placed at the center of every behavior, action and decision in the Trinity Health system. For Trinity Health, success will be measured against the Triple Aim objectives –its ability to actually deliver on all three dimensions of better health, better care and reduced costs.

Trinity Health has established a Unified Clinical Organization ("UCO") that provides a data and evidence-based infrastructure for clinicians across the Trinity Health system to

advance a culture of safety and high reliability. The UCO's goal is to consistently deliver the highest quality, safest and most efficient care for every patient, every time, in every Trinity Health location. Led by clinicians, the UCO offers a new way of working together to advance a culture of safety, quality, patient satisfaction and high reliability at each of our healthcare organizations.

Through the UCO, Trinity Health is:

- Advancing a culture of safety, with the goal of achieving zero clinical defects;
- Leveraging intellectual capital and best practices across Trinity Health;
- Becoming a world-class provider of care able to attract and retain the best talent, including physicians and other caregivers; and
- Delivering seamless care across the continuum of integrated health resources.

The UCO provides the infrastructure to make it easier for Trinity Health's affiliated clinicians and associates to deliver the finest care to each patient. Trinity Health-New England, Inc. will have access to this infrastructure and will participate in UCO initiatives. Examples of recently completed initiatives include cardiac surgery, interventional cardiology, palliative care, ambulatory heart failure and ambulatory diabetes. Additional collaboratives currently in the implementation, improvement and control phases are: sepsis, diabetes, perinatal safety, joint and spine surgery, peri-operative, falls, medication reconciliation and emergency medicine.

To date, the results of these initiatives have been impressive. Recent system-wide safety accomplishments across Trinity Health include:

- Sepsis mortality rate decreased from 15.8% to 11.2% between FY 2010 and December 2014. Total lives saved from FY 2010 to December 2014 = 2328.
- Vaginal Birth After Cesarean Section (VBAC) serious reportable events remain at zero, following a new policy implemented in April 2009.
- Elective deliveries before 39 weeks decreased from 4.7% in April 2010 to 0.5% in January 2015 for Trinity Health.
- Medication Reconciliation composite score (both admission and discharge data) has stayed consistent at 88% in FY2015 year to date.
- The Pressure Ulcer rates have declined from 3.8% in FY 2008 to 0.01% in January 2015 for all of Trinity Health.
- Severity Adjusted Mortality rate is at 83% of the expected rate in FY2015 for all of Trinity Health.
- Sponge accounting - zero retained sponges in FY 2014 for sites post-sponge accounting implementation.

- Safety Checklist Perfect Patient Score improved from 48% January 2013 to 81% July 2014.

Additionally, Trinity Health sponsors the annual Trinity Health Clinical Conference. The conference features leading industry professionals and nationally recognized leaders and showcases best practices. The conference includes numerous concurrent workshops presented by Trinity Health's RHMs describing proven methods to reduce costs, improve safety, quality, and service and increase employee and patient satisfaction with "take-home" implementation strategies.

Further, Trinity Health has adopted the Magnet Recognition Program® as the framework upon which its nursing program is being built. The Magnet Recognition Program® recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Consumers rely on Magnet designation as the ultimate credential for high quality nursing. Developed by the American Nurses Credentialing Center, Magnet is the leading source of successful nursing practices and strategies worldwide. A number of Trinity Health's nursing leaders are Magnet appraisers, and the directors across Trinity Health share their expertise, programs, and best practices through a monthly support network meeting. Trinity Health actively promotes academic progression and advanced education for nurses.

Last, Trinity Health sponsors a number of education and training programs focused on increasing clinical quality and patient safety. Currently, sharing of best practices occurs through the Trinity Health Clinical Leadership Council ("CLC"), a nationwide organization comprised of Trinity Health Chief Medical Officers, Vice Presidents of Medical Affairs and Chief Nursing Officers. The CLC sponsors system-wide clinical improvement teams and facilitates the exchange of comparative data regarding clinical and operational performance. The CLC meets two to three times per year in person and has monthly teleconferences focused on quality care and patient safety.

SMHS will participate in all these programs, taking away best practices and additional learnings to supplement its favorable quality and patient satisfaction scores. In short, Trinity Health's approach to clinical quality will complement and build upon SMHS strong clinical quality. This combined approach to clinical quality will significantly benefit SMHS patients.

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

This proposal will preserve local access to healthcare for the patients in the SMHS service area, including the indigent and Medicaid recipients by providing a greater

level of long term financial stability for SMHS. The integration of SMHS into the NE-RHM is anticipated to enhance access and quality of health care.

The proposed transaction will facilitate the continuation of SMHS's 108+ year commitment to providing health care services to patients in the communities it serves in the dynamic and changing environment of health care delivery. SMHS will build on this foundation and its own long-standing commitment to quality and clinical excellence. As previously noted, the NE-RHM is well recognized for its commitment to quality care as evidenced by the extensive list of awards and recognitions (See **Exhibit 9)**, and will be an excellent partner for SMHS.

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

As outlined in the answer to Section 1 of this application, the integration of SMHS into the NE-RHM is the best and most viable option available to assure the long term access to health care services for SMHS's target population.

As part of the integration of SMHS into the NE-RHM, the service line and support platform approach described previously will be used to enhance the quality of the services provided by SMHS, ensure the continuity of the service delivery system, close gaps in services where possible and reduce the costs of some services based on group purchasing contracts or specific service contract replacements.

While an overall decrease in inpatient volume is anticipated across healthcare due to a shift towards population health management, it is projected that the Hospital's average daily census will continue to be strong through coordinated care delivery and the availability of the NE-RHM infrastructure and service line support. Overall, it is anticipated that outpatient volume will increase over 6% by FY 2019.

The financial documents contained in **Exhibit 17** indicate the financial impact of the proposal and include the following:

- $100 million in capital investments within the first five years with a focus on strategic growth and infrastructure development and expansion and upgrades of facilities, services and equipment.
- Annual cost savings of approximately 1% of SMHS current operating expense in the areas of purchased services, supply chain, insurance and risk management, treasury, tax and compliance.

The NE-RHM and SMHS are committed to preserving a viable health care organization dedicated to providing health care services that meet the needs of the Saint Mary's community for the foreseeable future. Together the new health care organization formed as a result of this merger will be more than the sum of its parts; the new organization will improve the community's health by delivering high quality, cost effective, coordinated care across a broad continuum.

10. How will this proposal help improve the coordination of patient care (explain in

detail regardless of whether your answer is in the negative or affirmative)?

SMHS joining the NE-RHM delivers many benefits which will improve the coordination of patient care including:

- Investments in a shared information services infrastructure for the health ministry, it will allow for ease of sharing data and collaborating on population health management initiatives;
- Increased access to options to care offered by the NE-RHM and its partners;
- A strong commitment to people centered care and population health; and
- Providing better use of limited health manpower resources through combination of the treatment of specific patient populations e.g. cancer cardiovascular services and joint replacement services between the two organizations.

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

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

Medicaid and indigent persons will have the same access to the high quality services that they currently have. There will be no change in access to services for Medicaid recipients and indigent person as a result of this proposal. Please see response to Question 4j, Supplemental CON Application Form for Transfer of Ownership of Hospital for information on charity care and financial assistance for indigent person.

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

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

This question is not applicable because Medicaid recipients and indigent persons will continue to be served by SMHS irrespective of this proposal. Please see response to Question 11 above.

13. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from

this proposal, including, but not limited to, the addition of any imposed facility fees.

SMHS has been a vital part of the healthcare infrastructure of the Greater Waterbury region for over 108 years. Preservation of this healthcare resource ensures access to primary care providers as well as a wide range of outpatient, emergency and inpatient services. SMHS delivered over $290 million dollars to individuals in 2015 alone. (See **Exhibit 17**).

Neither the NE-RHM nor SMHS has charged facility fees for most of the organizations' services. In letters provided to the Attorney General in December 2013 (See **Exhibit 18**), NE-RHM identified three locations where facility fees are charged and SMHS identified five. Patients are informed of these facility fee charges in writing before services are delivered.

No new facility fees will occur as a result of SMHS joining the NE-RHM.

Financial Information

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

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

In an era of healthcare reform and diminishing resources, the transfer of SMHS's membership to the NE-RHM is consistent with the goals of the Department of Health's Statewide Health Care Facilities and Services Plan ("the Plan"). One of the guiding principles of the Plan is to "provide financial stability and cost containment of health care services".

The NE-RHM has long been focused on lowering the cost of delivering care by providing the right care at the right time in the right location. The NE-RHM also emphasizes meeting or exceeding quality standards in the delivery of care. Recognition of the high quality of all three Applicants is included elsewhere in this application in the listing of awards received from various health care quality ranking organizations such as the Leapfrog organization, The Joint Commission, US News and World Report to name a few. The NE-RHM also believes in healthcare innovation as a way to promote both quality and cost containment. The NE-RHM was also an early adopter of partnership arrangements with its physicians designed to ensure high improvements in quality, enhanced patient outcomes and efficient management of health care resources both financial and clinical occurred within its system as well as the use of Value Analysis in its Materials Management Department to generate

group purchasing savings.

The history of Saint Francis Hospital and Medical Center and Mount Sinai hospitals is relevant to this application because it demonstrates the value and cost savings that result from consolidation. As SMHS becomes part of the NE-RHM, it will also have the advantage of working within a system with a strong record of providing cost containment measures as it improves the quality of care.

Saint Francis Health*Care* Partners:

Saint Francis/Mount Sinai Physician Hospital Organization (PHO) was incorporated on June 17, 1993 as a not-for-profit, 501c3 taxable organization as Saint Francis Hospital and Medical Center and Mount Sinai Hospital were in the midst of merging and uniting the two medical staffs. The name was legally changed to Saint Francis Health*Care* Partners (SFHCP) on January 27, 2009.

Today, Saint Francis Health*Care* Partners ("SFHCP") is a clinically integrated network of physicians comprised of independent healthcare practitioners, hospital based or affiliated groups and other facilities that serve as a vehicle through which the clinical and related economic interests of patients, providers and payers become aligned. As the oldest functioning PHO in Connecticut, SFHCP is recognized both locally and nationally. The vision created by the initial thought leaders and advanced through a physician led Board of Directors and by the strong alliance between Chris Dadlez, CEO of Saint Francis Hospital and Medical Center, and Jess Kupec, CEO of Saint Francis Health*Care* Partners. The strength of sharing a common vision has propelled the organization into a nationally recognized ACO. Throughout SFHCP's twenty-one year history, SFHCP has been recognized by the healthcare industry for our physician leadership in driving a contemporary approach to improving quality and reducing unnecessary costs. SFHCP was one of the first organizations nationally to develop an integrated approach to implementing an Electronic Health Record (EHR). The alignment within the NE-RHM network has been so vital to its success that it will have full EHR adoption with its entire physician membership by the end of 2015. This is a significant accomplishment as compared to local and national benchmarks.

As a result of its depth of clinical integration, SFHCP has the ability to enter into contractual arrangements with the payor community that binds the entire membership by achieving minimum criteria for participation. As a result, the single-signature model fosters greater collaboration and network continuity. As market forces initiated by Federal reform have accelerated so too has our strategy. Employers and patients alike are now engaged and are demanding change. SFHCP realizes that the status quo is no longer acceptable and that the transparency of cost and quality are becoming the benchmarks for which employers and consumers will select where they receive their healthcare.

As SMHS becomes part of NE-RHM, it will have the advantage of working within a system with a strong record of providing cost containment measures as it improves the quality of care.

Foundation of our Contracting Model:

The commitment at NE-RHM to its patients is "best *care* for a lifetime". All components to our overall mission and focus begin there. Even our contract strategy is driven by being focused on providing the best options for its patients. The foundation of the contracting model is based upon a joint contracting relationship with Saint Francis Hospital and Medical Center and approximately 1,000 provider members. Through the years, this contracting model has derived its success by developing congenial relationships with the payor community. Through the joint contracting model, which is necessary in the attainment of the network's goals of financial stability, improving quality of care, reducing costs through efficiencies, and improving access to care, these relationships continue to be enhanced by its providers' commitment to achieving the best results for all patients accessing the Saint Francis Network.

The current contractual model is based upon the ideals of accountable care and shared savings – a collaborative approach with the payors in which all participating have the incentive to drive value to patients, including better quality, care coordination and total cost efficiency.

CMS Medicare ACO:

SFHCP has been developing its Accountable Care Strategy, with the intent of being prepared for the transition from a Fee for Service reimbursement model to an Accountable Care Organization (ACO) model which focuses on population management and the delivery of cost-effective, high quality care. SFHCP was recognized as an ACO by CMS and began participating in the CMS Medicare Shared Savings Program on January 1, 2013. Although the first year results were good, SFHCP did not achieve a level of savings allowing CMS to share these savings with the ACO. Although the organization did not meet the required minimum levels of savings, SFHCP did reduce costs by $1.1 million and achieved 5 out of 7 quality metrics. This is evidence that SFHCP is heading in the right direction and is a strong indication of our potential future success if we continue investing in our mission and vision.

Current Contracts:

SFHCP is currently contracted with the following major payors inclusive of these value-based components as noted below:

Value-Based Commercial Agreements:

Anthem, Inc.
Aetna, Inc.
CIGNA
ConnectiCare
UnitedHealthCare/Oxford- in progress

Covered Lives: 82,000

Value-based Medicare Advantage Agreements:

Anthem BlueCross BlueShield- in progress
Aetna, Inc.
ConnectiCare
UnitedHealthcare/Oxford
WellCare Health Plans

Covered lives: 31,000
Total covered lives: 113,000

Focus on the Future for SMHS:

As SMHS faces the challenges and opportunities presented by healthcare reform, the organization realizes the importance of executing a new business model that allows the entire SMHS enterprise to move in a strategic direction to meet the objectives of the Triple Aim[2]. SMHS's goal over the next couple of years is to build its infrastructure to such a degree that it is capable of accepting full risk opportunities. SMHS engagement with Trinity Health presents all organizations involved with a real opportunity to drive value to the market by improving cost to the individuals and employers while improving their healthcare outcomes.

With specific reference to the proposed affiliation with SMHS, the capabilities of SFHCP and potential for strategic alignment offer significant opportunities for both organizations and the patients they serve. SFHCP's demonstrated ability to collaborate effectively with payers and develop mutually beneficial business relationships will clearly assist SMHS, particularly as they transition away from a fee-for-service payment environment to a "population health management model". It is rather difficult for a hospital the size and scale of SMHS to build an infrastructure capable of succeeding under a risk-based population health model. Experience and trends at the national level clearly demonstrate this. Our integrated approach between our physicians and the acute care hospital setting can also serve as a model in our affiliation with SMHS.

Cost Containment Protocols

1. **Post-Acute Care Partnerships**: One of the substantial costs to the healthcare system is readmissions to the hospital. Readmissions occur for many reasons, one of which is poor coordination of care. Consequently, Trinity Health – New England, Inc. embarked upon the development of a post-acute care affiliated network that closely links the hospital to the continuum of post- acute providers including

2 The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim". (a)Improving the patient experience of care (including quality and satisfaction); (b) Improving the health of populations; and (c) Reducing the per capita cost of health care.

nursing homes and home health agencies. These tighter linkages provide for more accurate and seamless transitions of patients from the hospital to the next level of care and reduce the costly re-hospitalization of patients. The NE-RHM's commitment to continuing care for its patients is shown in the January 8, 2015 announcement of the formal Post-Acute Care Network through Saint Francis Health*Care* Partners, a NE-RHM affiliate, with the following long term care, rehabilitation and home care entities:

- Hospital For Special Care, in New Britain, CT
- Mount Sinai Rehabilitation Hospital in Hartford, CT
- Avon Health Center in Avon, CT
- Touchpoints at Bloomfield in Bloomfield, CT
- Touchpoints at Manchester in Manchester, CT
- Riverside Health and Rehabilitation Center in East Hartford, CT
- Glastonbury Health Care Center in Glastonbury, CT
    - McLean Home in Simsbury, CT
    - Evergreen Health Care Center in Stafford Springs, CT
    - Hughes Health and Rehabilitation in West Hartford, CT
    - The Reservoir in West Hartford, CT
    - Saint Mary Home in West Hartford, CT
    - West Hartford Health and Rehabilitation Center in West Hartford, CT
    - Kimberly Hall South in Windsor, CT
    - Masonicare Partners and Masonicare Home Health and Hospice

The post- acute affiliated providers will have access to the NE-RHM's Electronic Medical Record which will allow them real time access to patient discharge information. In addition, these providers have committed to implementing the INTERACT tool kit which focuses on readmission avoidance and will be participating in real time readmission reviews for any patient that has been readmitted to the NE-RHM.

Once SMHS joins the NE-RHM the system will create a similar agreement with a group of post - acute affiliated providers located in the Waterbury market place. This group of affiliated post – acute providers will use the comparable transfer agreements, have access to NE- RHM's electronic medical record and use the INTERACT tool kit to manage patient flow between the post – acute providers and SMHS.

2. Materials Management

The NE-RHM uses an internal Value Analysis Committee and its group purchasing agreements with Premier, Ascend and Yankee Alliance to drive costs down within its various clinical and non-clinical areas. Over the last three years this rigorous focus on value and price has generated over $11 million in savings for goods and services purchased by the NE-RHM. In addition, both NE-RHM and SMHS have participated in many state and federal surveys and discussions to improve healthcare delivery,

financing and provider supply.

3. Charity Care

Nothing in the proposed transfer of assets will reduce SMHS's or the NE-RHM's commitment to the provision of health care services to the poor, including the indigent and Medicaid patients. Saint Francis Hospital and Medical Center's inpatient and outpatient patient population is comprised of 23.8% Medicaid recipients in FY 2014 and SMHS's Medicaid population also represented 44% of its inpatient and outpatients in FY 2014. It is expected that this will remain level or increase in the coming years. Also, both organizations have and will continue to have self-pay and financial assistance policies if this proposed CON is approved. These policies are contained in **Exhibit 20**. For a more detailed explanation of the community benefit of both organizations, please refer to **Exhibit 21** which contains the 2014 Community Benefit Reports for Saint Francis *Care* (now known as NE-RHM) and SMHS. Both organizations are committed to charity care, which has a direct impact on the financial strength of the health care system in Connecticut.

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

Please refer to table 3 below**.**

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

This question is not applicable.

17. Include as an attachment:

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

Please refer to **Exhibit 22.**

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

Please refer to **Exhibit 17**.

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

Please refer to Table 4 below.

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

Please refer to **Exhibit 17**

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

There are no projected incremental losses from operations resulting from implementation of this CON proposal.

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

This question is not applicable.

Utilization

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

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

Please refer to **Table 5 and Table 6, *infra*.**

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

Patient volume is expected to remain constant for the next 4 years except for an expected decrease of 0.5% for Adult Medical and Surgical patients. This decrease is attributed to the continued shift from treating patients in the inpatient setting to the outpatient setting. As medical advances continue to decrease the need for

inpatient hospitalization, patients will increasingly be seen in as same day patients for surgeries or treated in ambulatory settings.

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

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

Please refer to **Table 7, *infra*.**

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

Please refer to response to question 8a in the Main CON application.

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

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

Please refer to **Table 8, *infra.* .**

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

Table 9 is not applicable since this proposal is an organizational change rather than a change in clinical services.

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

The NE-RHM does not believe this Certificate of Need proposal will have any effect on existing providers as there will be no expected change in any services at SMHS.

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

SMHS's affiliated providers currently have the option to refer to SMHS or elsewhere as they deem appropriate.

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

The existing referral patterns will remain unchanged.

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

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

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

This question is not applicable as this proposal will not result in an unnecessary duplication of services. All of SMHS's health services will remain as is if this proposal is approved.

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

The NE-RHM believes that SMHS is a unique part of the healthcare infrastructure of the State of Connecticut and a critical component of the health system in their primary service area. By SMHS joining the NE-RHM, the residents in the SMHS geographic service area can continue to receive services from the healthcare providers they currently have established relationships with in their communities. In this fashion this proposal preserves access to a diverse group of health care providers and ensures continued competition with the other healthcare organizations that serve patients in the region.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

This table is not applicable.

TABLE 2
SERVICE AREA TOWNS

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

Town*	Reason for Inclusion

*** Village or place names are not acceptable.**

Please refer to **Exhibit 11.** The 16 towns and 2 boroughs in the SMHS's Total Service Area have historically been the towns included in the Hospital's service area. These towns accounted for 93.5% of the Hospital's volume in FY2015.

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

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

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

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

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

This table is not applicable.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	TABLE 4 PROJECTED INCREMENTAL REVENUES AND EXPENSES FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	-	-	-	-
Total Operating Expenses	-	(1,585)	(3,133)	(3,241)
Gain/Loss from Operations	-	1,585	3,133	(3,241)

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

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs) FY 2012	FY 2013	FY 2014	FY 2015
DISCHARGES:				
Adult Med. & Surg.	23,879	24,318	23,264	23,951
Maternity	3,212	3,035	3,075	2,910
Psychiatric	2,010	2,064	1,961	1,961
Rehabilitation	650	685	660	705
Pediatric	-	-	-	-
Neonatal ICU	278	268	294	275
Newborn	2,732	2,681	2,640	2,535
TOTAL	32,761	33,051	31,894	32,337

1. Fiscal Year is October - September.

2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital.

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.**
**** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.**
***** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.**

TABLE 6
PROJECTED UTILIZATION BY SERVICE

SMHS

Service*	Projected Volume FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

Trinity Health – New England

SERVICE*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
DISCHARGES:				
Adult Med. & Surg.	26,699	32,486	32,560	32,383
Maternity	3,222	4,341	4,325	4,309
Psychiatric	2,130	2,508	2,498	2,489
Rehabilitation	883	759	759	759
Pediatric	-	-	-	-
Neonatal ICU	312	412	411	410
Newborn	2,750	3,626	3,612	3,598
TOTAL	35,996	44,132	44,165	43,948

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX
SMHS

Payer	TABLE 7 APPLICANT'S CURRENT & PROJECTED PAYER MIX									
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare	5,289	45%	5,313	45%	5,276	45%	5,240	45%	5,214	45%
Medicaid	3,703	31%	3,696	31%	3,683	31%	3,671	31%	3,653	31%
CHAMPUS & Tricare	22	0%	22	0%	22	0%	22	0%	22	0%
Total Government	9,014	76%	9,031	76%	8,981	76%	8,933	76%	8,888	76%
Commercial Insurers	2,601	22%	2,613	22%	2,604	22%	2,594	22%	2,581	22%
Uninsured	103	1%	102	1%	102	1%	101	1%	100	1%
Workers Compensation	129	1%	129	1%	129	1%	129	1%	128	1%
Total Non-Government	2,833	24%	2,844	24%	2,835	24%	2,824	24%	2,810	24%
Total Payer Mix	11,847	100%	11,875	100%	11,816	100%	11,757	100%	11,698	100%

Trinity Health-New England

Payer	CURRENT		PROJECTED							
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare *	14,821	45.8%	16,467	45.7%	19,643	44.5%	19,774	44.8%	19,678	44.8%
Medicaid*	7,962	24.6%	8,906	24.7%	11,864	26.9%	11,814	26.7%	11,756	26.7%
Champus & TriCare	77	0.2%	87	0.2%	112	0.3%	113	0.3%	112	0.3%
Total Government	22,860	70.7%	25,460	70.7%	31,619	71.6%	31,701	71.8%	31,546	71.8%
Commercial Insurers*	9,071	28.1%	10,046	27.9%	11,837	26.8%	11,783	26.7%	11,725	26.7%
Uninsured	268	0.8%	307	0.9%	401	0.9%	399	0.9%	397	0.9%
Workers Compensation	138	0.4%	183	0.5%	275	0.6%	282	0.6%	280	0.6%
Total Non-Government	9,477	29.3%	10,536	29.3%	12,513	28.4%	12,464	28.2%	12,402	28.2%
Total Payer Mix	32,337	100.0%	35,996	100.0%	44,132	100.0%	44,165	100.0%	43,948	100.0%

Assumptions:

1. FY 2015 (actual) includes only Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - FY 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's.

*** Includes managed care activity.**

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

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 15**
WATERBURY	59.3%
NAUGATUCK	9.4%
WOLCOTT	5.8%
WATERTOWN	5.3%
PROSPECT	3.2%
SOUTHBURY	1.9%
CHESHIRE	1.6%
THOMASTON	1.5%
MIDDLEBURY	1.4%
WOODBURY	1.2%
SOUTHINGTON	0.7%
OXFORD	0.6%
BETHLEHEM	0.6%
BEACON FALLS	0.5%
PLYMOUTH	0.3%
MORRIS	0.1%
Subtotal Total Service Area	**93.5%**
Other Towns	6.5%
Total	**100.0%**

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

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

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
N/A	N/A				

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

Supplemental CON Application Form
Transfer of Ownership/Sale of Hospital
Conn. Gen. Stat. § 19a-638(a)(2) & § 19a-486

Applicants: Trinity Health, Trinity Health-New England, Inc. and Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

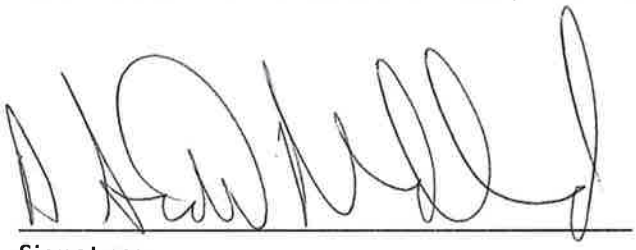
Project Name: Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.

AFFIDAVIT

Applicant: **Trinity Health**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **D. Scott Nordlund, Executive Vice President** of **Trinity Health** being duly sworn, depose and state that **Trinity Health's** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature

11·25·2015

Date

Subscribed and sworn to before me on 11-25-2015

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

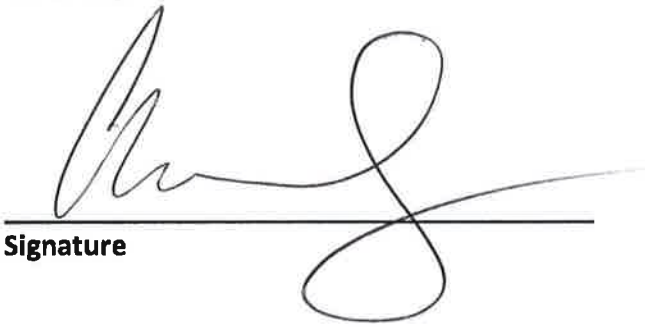
Claudia A. Crane, Notary Public
State of Michigan, County of Oakland,
My Commission Expires 11/17/2019
Acting in the County of _____

AFFIDAVIT

Applicant: **Trinity Health-New England, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, Christopher Dadlez, President and Chief Executive Officer of Trinity Health-New England, Inc., being duly sworn, depose and state that **Trinity Health-New England, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature 11-20-15 **Date**

Subscribed and sworn to before me on 11-20-15

Jaxeanne Christina Lubin-Scafuredi, Esq.

Notary Public/Commissioner of Superior Court

~~**My commission expires:**~~ _____

AFFIDAVIT

Applicant: **Saint Mary' Health System, Inc. and Saint Mary's Hospital, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **Chad Wable, President and Chief Executive Officer** of **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** being duly sworn, depose and state that **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 11/23/15 Date

Subscribed and sworn to before me on 11/23/15

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

My commission expires: VICTORIA CIPRIANO NOTARY PUBLIC MY COMMISSION EXPIRES FEB. 28, 2017

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

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

Because clinical health services are not being directly affected by this proposal, patient care will not be affected. Therefore, the typical type of transition plan is not needed where patients have to be moved or transitioned physically to other services because of a lack of continuity. If clinical services are added or eliminated in the future, the Applicants will seek a Certificate of Need as required.

The initial transition in this proposal will be directed at steps toward operational integration that would have a positive impact on the delivery of clinical services to patients of SMHS into the NE-RHM, and for identifying opportunities to achieve efficiencies and improvements in quality and access of health care services.

The NE-RHM has taken the additional steps in its relationship with SMHS by signing the Transfer Agreement (see **Exhibit 3**).

If the Certificate of Need is granted by the Office of Health Care Access, then NE-RHM plans to complete the acquisition of SMHS by 10/1/16.

The integration of SMHS under the NE-RHM organization will benefit both organizations and the community by ensuring the ongoing operation of SMHS, thereby continuing its 108+ year legacy of providing quality healthcare services in the Waterbury, Connecticut area.

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

i. Legal chart of corporate or entity structure including all affiliates.

The corporate organization charts are attached in **Exhibit S1**. The proposed organization charts provided include the NE-RHM (which will include SFHMC) and SMHS as part of this new organization. (See **Exhibit 4**)

ii. Governance or controlling body.

SMHS currently has a self-perpetuating community-based board of 21 members.

Reserve powers are held by the Archbishop of the Archdiocese of Hartford. Under the proposed new governance structure, NE-RHM (whose sole member is Trinity Health) will be the sole member of SMHS. Two members of the NE-RHM Board of Directors will be appointed by Trinity Health for a period of three years, with eligibility for re-appointment. These members will be from the SMHS community. The SMHS Board will remain unchanged other than the addition of the CEO of Trinity Health – New England, who will be an ex-officio member.

iii. **List of owners and the % ownership and shares of each**.
The applicants are non-stock, non-profit corporations and have no equity owners. **Exhibit S1** illustrates the percentage ownership of each of the SMHS affiliates. The proposed organization charts provided include the NE-RHM and SMHS as part of this new organization (**Exhibit 4**).

2. Historical and Projected Volume

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

TABLE A
HISTORICAL AND CURRENT DISCHARGES

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs) FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	23,879	24,318	23,264	23,951
Maternity	3,212	3,035	3,075	2,910
Psychiatric	2,010	2,064	1,961	1,961
Rehabilitation	650	685	660	705
Pediatric	-	-	-	-
Neonatal ICU	278	268	294	275
Newborn	2,732	2,681	2,640	2,535
TOTAL	32,761	33,051	31,894	32,337

1. Fiscal Year is October - September.
2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital

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

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

F/N The Applicants' Fiscal Year is from October 1 – September 30.

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	41,395	41,900	40,663	40,360
Maternity	2,775	2,609	2,855	2,775
Psychiatric	3,994	4,099	3,993	4,139
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,390	1,303	1,240	1,227
Newborn	2,022	1,922	2,173	2055
Total	**51,576**	**51,833**	**50,924**	**50,556**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	119,951	122,793	116,294	117,978
Maternity	10,105	9,478	9,630	8,732
Psychiatric	14,856	14,999	14,627	14,738
Rehabilitation	9,274	9,378	8,542	8,839
Pediatric	-	-	-	-
Neonatal ICU	6,018	5,626	5,010	5,068
Newborn	6,604	6,479	6,307	5,974
TOTAL	166,808	168,753	160,410	161,329

1. Fiscal Year is October - September.

2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital

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

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.)

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

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

TABLE C

PROJECTED DISCHARGES BY SERVICE

SMHS

Service*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

TRINITY HEALTH - NEW ENGLAND, INC.

SERVICE*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	26,699	32,486	32,560	32,383
Maternity	3,222	4,341	4,325	4,309
Psychiatric	2,130	2,508	2,498	2,489
Rehabilitation	883	759	759	759
Pediatric	-	-	-	-
Neonatal ICU	312	412	411	410
Newborn	2,750	3,626	3,612	3,598
TOTAL	35,996	44,132	44,165	43,948

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

SMHS

Service*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	40,900	40,645	40,392	40,140
Maternity	2,914	2,914	2,914	2,914
Psychiatric	3,769	3,769	3,769	3,769
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,220	1,220	1,220	1,220
Newborn	2,228	2,228	2,228	2,228
Total	**51,031**	**50,776**	**50,523**	**50,271**

Trinity Health – New England Inc.

SERVICE*	FY 2016	FY 2017	FY 2018
Adult Med. & Surg.	128,755	158,339	158,729
Maternity	9,402	13,005	12,954
Psychiatric	15,863	18,001	17,926
Rehabilitation	10,950	9,791	9,791
Pediatric	-	-	-
Neonatal ICU	5,402	6,330	6,311
Newborn	6,519	8,674	8,641
TOTAL	176,891	214,140	214,352

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

F/N The Applicants' Fiscal Year is from October 1 – September 30.

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

Overall, volume has remained relatively constant for the time periods reflected in the table above. The largest decrease was in overall days as the average length of stay continues to improve as a direct result of continuous improvements made in the efficiency of delivering care.

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

Inpatient volume is projected to decrease 0.5% each year, respectively, from FY 2017 through FY 2019 as utilization of inpatient services shifts to outpatient services as a result of increasing population health management.

3. Clear Public Need

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

No. The proposal is being submitted in accordance with OHCA requirements; however, the parties also intend to comply with all applicable federal and state antitrust laws and regulations.

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

While SMHS had planned to partner with another health care provider even before the PPACA was passed in order to have a system in the future that could support the kind of quality health care SMHS is accustomed to providing, there is no question that the PPACA only added further reasons to make this move now. With a shift from a fee for service structure to a population health focus, the PPACA requires an investment of time in new programming and information technology. This, in turn, requires a substantial commitment of capital, and is better made with a partner who has already had experience in this area.

4. Supplemental Questions

a. Were alternative proposals or offers considered and, if so, how did they compare to this proposal with respect to provider diversity, consumer choice and access to affordable quality health care?

Alternative proposals were considered. Trinity Health and NE-RHM have an outstanding model for diversity of services as well as a strong program to serve diverse populations. Consumers will select the best quality health care that is affordable. Trinity Health and NE-RHM have made their services affordable in the past and plan to continue to do so in the future.

b. For the first three years following the hospital's transfer of ownership, provide a detailed list and explanation for any consolidation, reduction, elimination or expansion of existing services, or any new services planned to be introduced.

As of the filing of this application, there are no planned changes to services offered by SMHS within its service area. As part of the NE-RHM, SMHS will continually monitor demand for services and adapt to them either through its existing offerings or collaboratively through the regional health ministry.

c. Please provide a detailed explanation of any planned staffing changes following the hospital's transfer of ownership and discuss how these changes will impact the accessibility, quality and affordability of care.

As of the filing of this application, there are no planned staffing changes that will occur in the near term as a result of this proposal.

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

The Greater Waterbury Health Improvement Partnership ("GWHIP"), which includes Saint Mary's Hospital, Waterbury Hospital, the City of Waterbury Department of Health, the Connecticut Community Foundation, StayWell Health Center, the United Way of Greater Waterbury and other community partners conducted a comprehensive Community Health Needs Assessment ("CHNA") in 2013. The community health issues identified in the CHNA as priorities and areas of focus were: (1) Access to Care; (2) Mental Health and Substance Abuse; (3) Obesity and Chronic Disease; and (4) Tobacco Use. A copy of the CNHA is attached as **Exhibit 5**.

Saint Mary's Hospital ("SMH") developed an Implementation Strategy that addresses the four community health priorities. SMH's Board of Directors met on September 12, 2013, to review the findings of the CHNA and the Implementation Strategy. The Implementation Strategy is attached as **Exhibit S2** and is being rolled out over three years. On September 12, 2013, the Boards of Directors of SMHS and SMH voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives (see **Exhibit 10** for Board minutes). To date, the following has occurred.

Access to Care Initiatives

- Collaborating with Access Health CT to help residents gain access to health insurance. SMH hosted several enrollment fairs during the 2013 – 2014 enrollment period.
- SMH transitioned ownership of the Children's Health Center ("CHC") to StayWell Health Center. This allowed the CHC patients to access StayWell's extensive offerings of health and social services.
- SMH developed and implemented a nurse navigator program in the Emergency Department ("ED") to improve access to primary care and behavioral health. The nurse navigator reviews between 60 and 200 patient records per week. The navigator contacts many of these patients to coordinate follow-up care and connect patients with other resources.
- Educating health care providers on resources for uninsured/underinsured and low income patients.
- Providing free screenings for uninsured and underinsured patients. For example, SMH provides free breast and cervical cancer screenings, diagnostic and treatment referral services through a Connecticut Department of Health grant.

Mental Health and Substance Abuse Initiatives

- A "Super Track" initiative has been implemented in the ED. This initiative has led to improved patient flow, reduced length of stay, and increased patient satisfaction.
- SMH is a participant in the Connecticut Behavioral Health Partnership, which is organized through Value Options.
- Evaluating ways to implement the Community Care Team program based at Middlesex Hospital.

Obesity and Chronic Diseases Initiatives

- Collaborating with Brass City Harvest to offer a farmer's market every Friday during the summer months for local residents.
- Participating in the American Heart Association Mission Lifeline Program.
- Developing improved meal choices at SMH. SMH began offering the Mindful Meal program, which includes healthy low-fat and low calorie options, to patients, staff and the community.
- Providing a nurse educator to patients to coordinate post-acute services and provide patient and family education. SMH is one of eleven hospitals in the country to participate in the American College of Cardiology Patient Navigator Program.

Tobacco Use Initiatives

- Working with the Harold Leever Regional Cancer Center to enhance smoking cessation programs.
- Evaluating opportunities to pilot an incentive program to increase smoking cessation rates.

The implementation of these initiatives will be greatly enhanced as SMHS becomes a member of the NE-RHM.

Following the initial CHNA, the work of the Greater Waterbury Health Improvement Partnership has continued. This year we completed a new survey, the Behavioral Risk Factor Surveillance System (BRFSS). This is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. In Waterbury, more than 400 members of the community were surveyed. Results from the survey will be integrated with the original CHNA to develop a more comprehensive view of the health of our community, and to further focus and refine our efforts. Workgroups focused on the four priority health areas continue to meet on a monthly basis, and a steering committee provides oversight of the entire process.

Most recently, the Greater Waterbury Health Improvement Partnership (GWHIP) has been accepted to participate in the Centers for Disease Control and Prevention (CDC) pilot Learning Collaborative for Community Health Improvement (CHI).

As part of the Learning Collaborative, SMHS and our community partners will be joining nine other CHI partnerships from around the country to learn about the CHI process and its underlying principles in greater depth, and to use the CHI Navigator to strengthen our ability to conduct an effective and collaborative CHI process. This program is designed to provide training and group technical assistance through a series of webinars and phone calls from national community health improvement experts as well as facilitated peer-to-peer sharing and learning with other CHI partnerships.

The NE-RHM Community Need Assessment, (**Exhibit 21**) as filed with the Office of Health Care Access, identifies similar priorities and areas of focus. Implementation strategies employed by the NE-RHM will buttress the strategies currently in place in Waterbury. In this document there are listed problem areas including obesity, diabetes, behavioral health, and alcoholism and substance abuse. These disease categories are also discussed as prevalent chronic diseases in Connecticut that need to be improved upon in The Department Of Health Publications called “Healthy CT 2020” published in March 2014 and “Live Healthy CT” published in April 2014. The Applicants also reviewed the “Statewide Health Care Facilities and Services Plan 2014 Supplement” which identifies at risk and vulnerable populations in Connecticut in chapters 3 – 5.

As shown in the NE-RHM implementation plan, the organization is addressing these diseases by offering related classes to improve the population health in its community. The NE-RHM also currently services many patients with chronic diseases in its various service lines including Primary Care, and Behavioral Health. The NE-RHM has an outpatient Diabetes Care Center that serves many people with Diabetes and offers many outreach and educational activities within the community that address these chronic diseases. The NE-RHM and SMHS understand the importance of treating and improving the overall health of its populations. SMHS will benefit from the NE-RHM's knowledge and experience with improving chronic diseases.

The NE-RHM has also made it a priority to address health equity as evidenced by the establishment of the Curtis D. Robinson Center for Health Equity (CDRCHE) in 2011. Curtis D. Robinson is a NE-RHM board member, African American business leader and cancer survivor. The CDRCHE grew out of a community engaged program focused on the disparity in health outcomes of African American men impacted by prostate cancer. Over the years, the CDRCHE team has addressed health disparities by community engagement; providing health education and outreach to underserved communities; offering tailored navigation for patients; and participating in research and data analysis about health disparities for the community served by the NE-RHM. The CDRCHE serves as a platform throughout the NE-RHM to address health equity issues by bridging the divide between the community and the healthcare system and focusing on a long term commitment to change. This organization and its approach will be available for SMHS as well.

The NE-RHM Strategic Implementation Plan (developed by the CDRCHE and approved by leadership) outlines four priorities that highlight a "systems change" approach to resolving the issues identified in the Community Health Needs Assessment. The four strategic priorities are: Improving Communication; Addressing Barriers to Healthcare Services; Providing Coordinated Care and Targeting Social Determinants of Health. Within each of these priority areas specific activities have been developed, with input from those affected, to address the identified need. The community outreach approach integrates input from healthcare providers, community agencies and those in need of services.

Some of the activities that have been developed to address the four priority areas within the NE-RHM include: the development of a language services program; increased commitment to cultural competency training; focus on appropriate use of Emergency Room resources; engagement with community groups to navigate patients to needed resources; partnering with state agencies to provide critical training to communities with limited resources for mental health support; and collaborating with faith communities to address chronic health conditions of concern within their institutions. Each of these activities will be replicated and tailored to address the needs identified within the communities reached by the NE-RHM.

The priorities of the Connecticut Department of Public Health are outlined in the Health Promotion Plan published in 2014 entitled "Live Healthy Connecticut". In this document, Dr. Jewell Mullen, the state Commissioner of Public Health, identifies three strategies as necessary for success of the plan (which are parallel to those identified in our strategic implementation plan), they include: an environmental approach which acknowledges the need for change outside of the healthcare system to achieve sustainable outcomes (addressing social determinants of health); improving the system for delivery of care which ensures access to healthcare services (decreasing barriers to care) and improving linkages between the community and clinical settings (communication and coordination of care).

In addition, the Statewide Health Care Facilities and Services Plan, the 2014 Supplement and the Healthy CT 2020 consider multiple determinants of health and provide an overview of initiatives focused on reducing health inequities, improving health outcomes and enhancing care coordination all of which are priorities for the NE-RHM going forward. In fact, Dr. Marcus McKinney, D.Min., Vice President of Health Equity and Health Policy at the NE-RHM, was the co-chairperson of the work group on Mental Health, Alcohol and Substance Abuse which set the priorities for this area of work. Dr. Marcus McKinney's work on this work group shows the NE-RHM's commitment to addressing health inequities.

In addition to the above activities, Dr. McKinney is also engaged in national activities surrounding health disparities. For instance, as part of the NE-RHM's effort to encourage other institutions to develop programs that encourage health care organizations to reach out to populations that often have difficulty accessing the traditional health care system, Dr. Marcus McKinney presented "Simple Solutions in Health Equity; Bridging communities to Health Systems" at the 2015 National Catholic Health Association General Assembly on June 7, 2015 in Washington D.C.

The Curtis D. Robinson Center for Health Equity exists to engage and empower community members to collaborate with healthcare providers and create innovative programs that address identified health disparities. The Curtis D. Robinson Center encourages communities who have not been heard to reach out to health providers and help shape the trajectory of change in healthcare. Relationships with the community, Catholic Charities and other human service organizations are discussed and successful approaches to a collaborative dialogue will be identified in the presentation.

The NE-RHM is also beginning its efforts related to its 2015 Community Benefits report. For the 2015 Community Health Needs Assessment, the NE-RHM has partnered with Data Haven, a non-profit organization with a 25-year history of public service to Greater New Haven and Connecticut whose mission is to improve quality of life by compiling, sharing, and interpreting public data for effective decision making. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, DC.

Clearly, given the above, the NE-RHM and SMHS are currently addressing the community needs within the SMHS community and the state of CT and will continue to do so if this CON is approved. Also, SMHS's efforts will be significantly enhanced and expanded with the expertise, experience and support of the NE-RHM if this CON application is approved.

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

If the proposal is approved, a review of the NE-RHM, Trinity Health and SMHS's current charity care, uncompensated care, financial assistance policies and procedures and bed funds will be reviewed to ensure compliance with new requirements effective January 1, 2016.

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

SMHS currently collaborates with both FQHC's located in Waterbury (StayWell, Community Health Centers, Inc.). These relationships will continue as SMHS provides acute care and behavioral health services for these patients whose medical home is either one of these FQHCs.

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

As noted earlier in the application, the NE-RHM has committed to ensure capital investment at SMHS of $100 million over the first five years after closing for routine capital, information technology and other capital needs. Historically, SMHS's has been investing on average $12 million per year in routine capital. This proposal will allow SMHS to accelerate these investments to maximize the efficiency and effectiveness of the delivery of care.

SMHS's current routine capital needs over the next five years include the following:

- Hospital facility upgrades $22 million
- Replacement of clinical equipment $18 million

In addition, based on preliminary SMHS strategic planning efforts, additional capital is needed for strategic investments and would likely include:

- Information technology upgrades and electronic health record $12 million
- Urgent care / ambulatory care $10 million
- Ambulatory pavilion on campus $25 million

- Convert to private patient rooms $8 million
- Clinically integrated network development $5 million

As healthcare continues to evolve, the allocation of capital to SMH's and the NE-RHM strategic initiatives will be integrated with the Trinity Health strategic and financial planning process.

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

- Cancer care is a key priority. Due to the aging of the population, cancer care is an important service to the community. Through the recently announced clinical affiliation with Smilow Cancer Hospital and Yale New Haven Hospital, the NE-RHM cancer program will utilize the same clinical guidelines as Smilow. Furthermore, as the only NCI designated cancer program in the state, patients of SMHS following the transaction, will have access to state of the art clinical trials and treatments.
- Movement towards ambulatory surgery is a national and local trend. This enables care to be delivered in the lowest cost setting with the best outcomes for the patient.
- Population Management is essential to develop. The NE-RHM has already developed a robust heart failure program that will be a priority to extend to SMHS not only for inpatients but across the continuum including the skilled nursing facility and in the ambulatory setting. The NE-RHM has realized improvements in readmission rates and will readily extend this expertise to SMHS.

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

It is anticipated that SMHS will maintain their current Medicare and Medicaid provider numbers and there will be no changes to those contracts as a result of this proposal. After the implementation of this proposal, SMHS will continue will continue to operate under its own license and its current commercial contracts are expected to remain in effect. Upon expiration of current commercial contracts, SMHS contract negotiations will be part of the broader the NE-RHM payor contracting process.

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

As noted previously, the applicants will develop a plan to adequately fund Saint Mary's pension obligations.

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

The existing high quality of care of both the NE-RHM and SMHS will be maintained if this Certificate of Need is approved. Also, please refer to response to 9a in the Main CON.

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

See **Exhibit S3**

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

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

See **Exhibit S4**

ii. annual or periodic review and/or revision to the hospital's pricing structure (chargemaster or pricemaster); and

SMHS performs annual and periodic CPT/HCPC/revenue coding updates and revisions per applicable changes from AMA and Medicare. SMH pricemaster is adjusted throughout the year as costs for supplies change. Our contracts have pricemaster increase thresholds. There are no plans to change this process as a result of this proposal.

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

SMHS performs periodic market assessments and pricing sensitivity analyses on an as needed basis. There are no plans to market assess as a result of this proposal.

n. Provide <u>monthly</u> financial reports that include statistics for the current month, year-to-date and comparable month from the previous year for the following:

Monthly Financial Measurement/Indicators

Refer to **Exhibit 17**

o. For the most recent tax year, provide a copy of the Hospital's IRS Form 990 (you may reference the filing if previously submitted to OHCA). With respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H (Financial Assistance and Certain Other Community Benefits at Cost) and Part II of Schedule H (Community

Building Activities), provide a projected amount for each line item for the first three years following the change in ownership and describe the hospital's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H.

The most recent IRS Form 990 is attached in **Exhibit S5** along with the projected amount in **Exhibit S6**. SMHS is committed to supporting its community and is projecting a 3% increase per year. As part of the NE-RHM, SMHS will be able to collaborate on planning activities on a regional level leveraging the expertise and resources of the regional health ministry.

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

The NE-RHM currently participates in a national group purchasing program that provides advantageous pricing for many products and supplies. The proposal will allow SMHS to further benefit from this program as well as provide other opportunities with vendors such as information technology where SMHS will be able to leverage the buying power of NE-RHM.

The NE-RHM's continued focus on population health and the development of an infrastructure to support risk-based contracts with payers will also be available and a benefit to SMHS after the proposal is approved. This will allow SMHS to transition to risk-based contracting and position SMHS favorably with payers.

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

As the NE-RHM and SMHS continue to reduce costs through standardization of clinical protocols and clinical integration, the ultimate impact will be a decrease of costs to the consumer as these efforts will likely result in the elimination of duplicate services and removal of waste within the system and across the continuum of care. These savings have not been quantified at this time.

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

SMHS has several programs in place to adhere to the National Standards on Culturally and Linguistically Appropriate Services. SMHS has contracted with FSW (formerly Family Services Woodfield) to provide face to face sign language interpreters for the hearing impaired. Video conferencing is also available for sign language interpretation.

SMHS also contracts with Language Line Services, which provides translation for non-English speaking patients. Two handset phones are strategically placed within SMHS. The patient has one handset while the provider has the other handset. The Language Line Services' interpreter participates in the patient visit by providing translation over the telephone.

SMHS also participates in the Connecticut Hospital Association Diversity Collaborative (the "Collaborative"). As part of the Collaborative, SMHS hosts an educational fair during Cultural Diversity Week. At this fair, brochures on CLAS standards are distributed.

In addition, SMHS Hospital's Education Department has incorporated Cultural Diversity Training in the annual e-learning program, which is mandatory for all employees. Cultural Diversity Training is also part of new employee orientation.

Finally, SMHS Hospital's Education Department and Nursing Administration Department are evaluating other training programs to increase adherence to CLAS. SMHS will support these existing programs that increase adherence to CLAS standards.

The following is a description of the NE-RHM's efforts in establishing National CLAS Standards.

To address health disparities and prioritize health equity the NE-RHM led by its CEO, Christopher Dadlez, created the Curtis D. Robinson Center for Health Equity, a platform that supports and leads health equity initiatives – whose home is the first floor of the Urban League of Greater Hartford. In 2009 the Saint Francis Board of Directors passed a resolution that embraced the National Call to Action goals of increased use of Real Data, improved Cultural Competency Training, and more Diversity in Leadership. In 2011 the Curtis D. Robinson Center for Health Equity was founded and in 2012 it moved to a dedicated space designed to provide easy access to those who live in the surrounding community. The position of Vice President of Community Health Equity was established, and a dedicated, multicultural staff charged with transformation of our healthcare system based on AHA goals and the NE-RHM's unyielding commitment to community engagement which results in decreased health disparities in a meaningful and measurable way.

Activities at NE-RHM that fulfill the CLAS Standards include:

<u>*Governance, Leadership, and Workforce:</u>

- Updated training for intake staff on the collection of race and ethnicity implemented 3/2014.
- Updated policy for the use of language services implemented 9/2014

- Edits to the policies to explicitly include gay and lesbian populations for visitation completed 9/2014.
- 99% of staff trained for cultural competency in 2014

*Communication and Language Assistance:

- Language Program Developed: Increase in resources across the organization for addressing language services to include our 3 + 1 options (Dual Handset Phones; Video
- Remote Interpreting; In-person interpreting + Document Translation)
- Full Time Language Services Coordinator Hired 11/2014
- Signage regarding language services availability updated and replaced 12/2014
- Training for all staff on new language services resources completed 3/2015
- Pilot training for bilingual staff to become qualified medical interpreters completed in 9/2014
- System for translation of documents into needed languages on demand implemented 2/2015

*Engagement, Continuous Improvement, and Accountability:

- Leadership of the State Diversity Collaborative by the CEO of Saint Francis Hospital and Medical Center
- Collection and reporting of data for the CT Diversity Collaborative (Diversity in Leadership and Governance; Cultural Competency Training; Use of Diverse Suppliers)
- Quarterly reporting to the Board of Directors on Center for Health Equity activities
- Partnership with community organizations to respond to needs identified through assessment activities.
- Support of Diversity Intern through the Institute for Diversity in Healthcare Management
- Creation of an Accelerated Development Program for diversity staff
- Saint Francis Diversity Collaborative Team – regular meetings since 2011
- Development of a Health Equity Scorecard
- Regular Community Leader Roundtable Discussions
- Completion and Distribution of the Community Benefit Report
- Update of Saint Francis Hospital and Medical Center's website outlining activities and providing copies of relevant publications.

To address health disparities in a comprehensive and effective manner it is necessary not only to provide appropriate services but to change and improve those services so that they are accessible to all populations regardless of degree of English language proficiency; cultural beliefs; racial, ethnic and gender identities. Hence, the NE-RHM has updated three of its current policies addressing communication and language services,

patients' rights and equal employment and Affirmative Action. Please refer to **Exhibit S7** to see these policies. By making changes at the policy level, NE-RHM is able to hold all staff accountable for providing care which embraces inclusive strategies that have proven to impact health outcomes. For example, research has shown that providing information to patients with limited English proficiency in their native language can result in better health outcomes and patient satisfaction. See **Exhibit S8** for citation - "Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters." Research from NIH has concluded that implementation of cultural competency needs to take place at the systems level - as a "framework which enables systems, agencies and group of professionals to function effectively to understand the needs of groups accessing care." The NE-RHM is embracing this approach by making changes at all levels of the organization to address health equity disparities.

NE–RHM will support these initiatives with SMHS and is confident that they will continue and deepen if this proposal is approved.

Saint Mary's HOSPITAL

Certificate of Need

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EXHIBIT 1

Saint Mary's Hospital Awards and Accomplishments

2013

- ✓ Named a Top Performer on Key Quality Measures® by The Joint Commission for heart attack, heart failure, pneumonia and surgical care (2012 data)
- ✓ American Heart Association Get With The Guidelines®–Heart Failure Gold Quality Achievement Award
- ✓ American Heart Association/American Stroke Association Get With The Guidelines®–Stroke Gold Quality Achievement Award
- ✓ Named an American College of Cardiology Patient Navigator Hospital (among first 11 in nation)
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR®) ACTION Registry–GWTG Gold Performance Achievement Award for 2013
- ✓ American Heart Association's Mission: Lifeline® Bronze Receiving Quality Achievement Award for heart attack care; named a STEMI Receiving Hospital
- ✓ Recognized by BlueCross BlueShield Association as a Blue Distinction Center+ for Cardiac Care
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ Rated among the five highest scoring teaching hospitals in the country for safety by Consumer Reports (not an endorsement ; recognition cannot be published)
- ✓ Cancer Program awarded a three-year accreditation with commendation from the American College of Surgeons' Commission on Cancer (CoC)
- ✓ Nuclear Medicine Department awarded a three-year accreditation from the American College of Radiology for all nuclear cameras

2014

- ✓ Named a Top Performer on Key Quality Measures® by The Joint Commission for heart attack, heart failure, pneumonia and surgical care (2013 data)
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR®) ACTION Registry—Get With The Guidelines (GWTG) Gold Performance Achievement Award for 2014
- ✓ American Heart Association's Mission: Lifeline® Silver Plus Receiving Quality Achievement Award for heart attack/STEMI care
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ One of the top two hospitals for safety in Connecticut based on safety ratings from Consumer Reports (not an endorsement; recognition cannot be published)
- ✓ Awarded a $32,750 grant from Susan G. Komen Connecticut to provide screening mammograms, diagnostic mammograms and ultrasounds for women through the Navigating Breast Health Program, which is dedicated to reducing high rates of breast cancer mortality and late-stage diagnoses
- ✓ Received a $1.7 million reimbursement from the Centers for Medicare and Medicaid (CMS) for achieving the Stage 1 Year 2 objectives required to demonstrate meaningful use of our Electronic Health Record

- ✓ #1 in Connecticut for the CMS Value Based Purchasing program; performance based on quality and service metrics including CMS core measures, the Hospitals Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and mortality

2015

- ✓ Rated high performing in Heart Failure in the U.S. News & World Report Best Hospitals for Common Care ratings
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR) ACTION Registry–Get With The Guidelines (GWTG) Gold Performance Achievement Award for 2015
- ✓ Comprehensive Center accreditation from the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and the American Society for Metabolic and Bariatric Surgery (ASMBS)
- ✓ Recognized by Anthem Blue Cross Blue Shield with a Blue Distinction® Center designation in the area of bariatric surgery as part of the Blue Distinction® Centers for Specialty Care program
- ✓ Designated as an Aetna Institutes of Quality® (IOQ) facility for Bariatric Surgery
- ✓ Saint Mary's Urgent Care Centers in Naugatuck and Wolcott received the Certified Urgent Care designation from the Urgent Care Association of America
- ✓ Re-verified as a Level II Trauma Center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS)
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ Recognized as a Breastfeeding Friendly Worksite by the Connecticut Department of Public Health and the Connecticut Breastfeeding Coalition
- ✓ Named one of the 2015 America's Best Hospitals for Heart Care by the Women's Choice Award, a leading consumer advocacy group

cleverley+associates

2015 Community Value Leadership Award Winner

Community Value Five-Star®

Saint Marys Hospital

EXHIBIT 2

Healthcare Transformation Task Force Members

March 19, 2015

Providers Members

Advocate Health Care

Aledade

Ascension

Atrius Health

Dartmouth-Hitchcock Health

Dignity Health

Evolent Health

Heritage Provider Network

Optium

OSF Healthcare

Partners Healthcare

Premier

Providence Health & Services

SLL Health

SSM Health

Trinity Health

Tuscan Medical Center

Payers Members

Aetna

Blue of California

HCSC Health Care Service Corporation

Blue Cross Blue Shield Massachusetts

Purchasers Members

Caesars Entertainment

PBGH Pacific Business Group in Health

Patients and Families Members

National Partnership for Women and Families

Partners Members

The Dartmouth Institute

Mark McClellan, Brookings Institute

Patientping

remedy partners

Source: Healthcare Transformation Task Force website 3/19/15 www.hcttf.org

EXHIBIT 3

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01**.

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01**.

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06**.

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06**.

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02**.

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"**Certification of AFTAP**" has the meaning set forth in **Section 6.22(c)**.

"**Church Plan**" has the meaning set forth in **Section 6.22(e)**.

"**Closing**" has the meaning set forth in **Section 5.01**.

"**Closing Date**" has the meaning set forth in **Section 5.01**.

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01**.

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a)**.

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04**.

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth in **Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**NE-RHM**" has the meaning set forth in the preamble.

"**NE-RHM Controlled Subsidiary**" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"**NE-RHM Providers**" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"**Trinity Health Controlled Subsidiary**" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"Withdrawal Liability" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

cont do: a, b, c, o, q
consent for: d, e h, i, k, m, n, p
notify: f, g, j, l

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c),** and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a **"Covered Entity"** (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary (**"Interested Person"**) directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12**.

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06.** The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

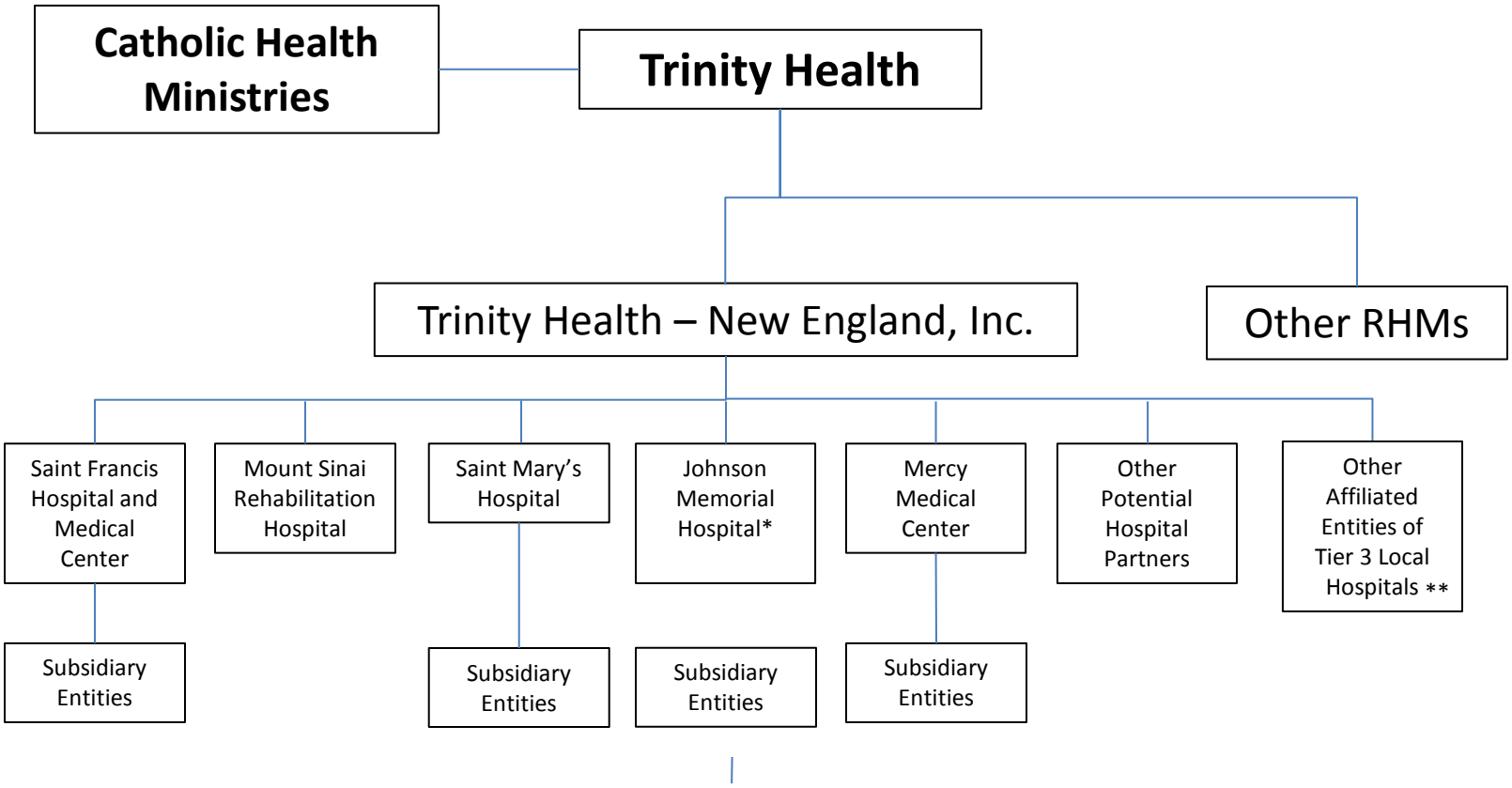
SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBIT 4



*(1/1/2016 anticipated closing date)

** This refers to non-hospital entities that are on the same level as the hospital entities noted, such as Saint Francis Medical Group, Inc., Saint Francis Hospital Foundation, etc.

EXHIBIT *5*

Saint Mary's Strategic Plan 2016-2020

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Introduction and overview

Introduction and Overview

The materials included in this document represent an update to the existing plan that was created last year. The strategies are rooted in our mission (which remains unchanged) and our vision, but have been fine tuned to reflect what we have learned and how the environment has evolved.

In 2014, our physicians, staff and community helped to craft a plan for 2015-2019 which contemplated advancing population health, establishing a Clinically Integrated Network and Accountable Care Organization and investing in Ambulatory care.

After living with it for nearly a year, we wanted to fine tune and continue to focus on the core elements of the plan. We have taken the time to incorporate suggestions from our physicians, staff and community on how to ensure that we are focused on the appropriate initiatives given the evolving healthcare climate both at Saint Mary's and regionally. Substantive change was made in the service line initiatives so that we are more focused and appropriating resources to successfully execute these initiatives.

We have also spent the year contemplating joining a system of regional/national health systems with the belief that joining the Regional Health Ministry will accelerate successful achievement of the plan. Saint Mary's is also focusing on Trinity's Healthy 2020 health wellness vision.

Strategic Plan Process

2016 Drivers of Strategic Plan

Payer Activity

1. Payer consolidation
2. Accountable care reimbursement changes like bundled payment plans and value based purchasing
3. Increasing demand for transparency
4. Payment models changing to reflect cost and/or quality

Provider Activity

1. Non traditional competition
2. Physician alignment and integration
3. Ongoing consolidation and partnerships of CT healthcare providers (hospitals, physician groups)

Consumer Activity

1. Growth in high deductible plans
2. Consumer directed choices (with assistance from upstarts/payers)
3. Increasingly interested in ratings adding to confusion of what they mean
4. Growing demand for convenient outpatient services as inpatient activity decreases

Mission and Values

Saint Mary's Health System provides excellent healthcare in a spiritually enriched environment to improve the health of our community.

"I Care" Values

- Integrity
- Caring
- Accountability
- Respect
- Excellence

Our vision (updated for 2016-2020)

Saint Mary's will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives.

Overall strategy & initiatives

Overall strategy

"Build the wall" – Provide care to our community within our network of trusted providers.

Strategic Initiatives

Strengthen the Core

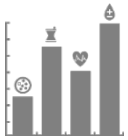
Drive continued, sustainable improvement in operations focusing on Quality & Safety, Service, Healthy People, and Financial Discipline

Cultivate a Clinically Integrated Network

Establish a team of care coordinators, strategic partnerships, structure, and support mechanisms to achieve a clinically integrated network, with coordinated care across our ecosystem

Service Line Strategy

Create comprehensive Cardiac and Primary Care service line strategy that encompasses the complete continuum of a patient's care allowing for leading levels of quality, service and efficiency



Signature Services Strategy Development

New!

Develop a laser focus on patient outcomes and experience, viewing the patient experience in a contemporary, collaborative manner with all care provided regardless of the patient's point-of-entry

Ambulatory Care Network

Create a network where every patient has access to primary care, urgent care, basic imaging and blood draw within 10 minutes of anywhere in our market

Strengthen the Core

- The core focuses on transforming our culture around the following:
  - Quality & Safety (Preventable harm & Core Quality Indicators)
  - Patient & Family Centered Service (Wait times & Satisfaction Scores)
  - Healthy & Engaged People (Health & Wellness)
  - Financial Discipline (Efficiency, Productivity, Revenue)

Strengthen the Core

SHORT TERM (1-2 YEAR) INITIATIVES

Healthy & Engaged People

- Design and implement a comprehensive wellness plan
- Design and implement a comprehensive workforce development plan

Quality & Safety

- Reduce Preventable Harm
- Improve Core Quality

Patient & Family Centered Service

- Improve the ED front end intake process
- Eliminate waiting throughout the system
- Transform services towards a Retail Orientation
- Fully optimize the patient feedback system

Financial Discipline

- Continue to improve productivity management
- Enhance cost management across the system
- Reduce overall fixed costs
- Revenue optimization

LONG TERM (3-5 YEAR) INITIATIVES

- Leverage the regional health ministry to enhance and improve all core initiatives.

Develop a Clinically Integrated Network

SHORT TERM (1-2 YEAR) INITIATIVES

- Creating the CIN structure
- Growing the attributed lives through physician alignment
- Develop and finalize payer contracting initiatives
  - MSSP
  - Anthem
  - Cigna
- Using data to improve care management
- Decrease clinical variation amongst CIN providers
- Prepare for regional system integration

LONG-TERM (3-5 YEAR) INITIATIVES

- Evolve payer contracts to risk based models
- Developing the care management models

Service Lines

Focus on Cardiac and Primary Care service lines because:

- Leverage existing service lines that have an organizational structure in place, will drive system revenue and increase market share
- Grow the number of attributed lives while preparing for the shift to population health management
- Support the Ambulatory Care Network Strategy through having primary care be one of the anchors for the access centers

Why these Two Service Lines?

Primary Care

- Foundation of referrals into the system
- Primary Care equals market share and controlling your market share
- Panel size vs. IP admissions
- Hub of the care team

Cardiac

- Strong foundation currently in place
- Currently provide a full range of services
- Market share is strong in a competitive market
- Relatively high margin for surgical procedures

Primary Care Service Lines

Goal is by 2020 to have a well managed population with 65,000 attributed lives

Short Term (1-2 Year) Initiatives

- Achieve a PCMH Level 1 designation for FMG
- Create a unifying branding approach
- Continue to recruit primary care providers to either FMG or VHA
- Open 2 Centers collocating with urgent care, x-ray, lab and specialists
- Created a referral management improvement process

Long Term (3-5 Year) Initiatives

- Create a consistent patient experience regardless of location
- Open 3 more Outpatient Centers
- EHR upgrade to allow for expedited data sharing, scheduling and integration
- Achieve a Patient Centered Medical Neighborhood designation

Focus Areas

- Retail strategy
- Smart growth
- Access

Cardiac Service Line

Goal is to increase market share to equal overall Saint Mary's market share

Short Term (1-2 Year) Initiatives

- Organic Growth across all services
- Continued development of the Electrophysiology ("EP") Program
- Expand access to services
- Provider recruitment and retention

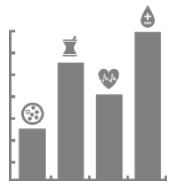
Long Term (3-5 Year) Initiatives

- Maintain a competitive edge through ensuring contemporary technology
- New service growth
- Improve quality and efficiency

Focus areas

- Outpatient growth
- Reduce outmigration
- Enhancing programs for patient convenience

Signature Services



Services that are strategic in nature and play a supporting role in the overall strategy. Work continues on them as planned.

Surgical Services

- Bariatric
  - Leverage the Centers of Excellence designation
  - Grow volume through additional provider capacity and capabilities
  - Evolve to a weight management program
- Robotic & Minimally invasive surgery
- Ambulatory surgery
  - Co-Management with NVSC

Neuro Spine

- Spine Surgery
- Head and Neck
- Co-management

Women's Services

- Focus on the Spirt of Women program
- Grow the Women's and Infants service

Emergency Department

- Reduce the front end wait
- Continue to implement the redesign of patient flow

Key Strategic Clinical Services in Development

Following services are in a planning and development stage and will be further refined within the year.

Oncology

- Need to leverage Smillow and Leever market awareness
- Comprehensive Breast Strategy
- Cancer patients require a holistic approach to care along the whole continuum
- Diagnosis, treatment and survivorship can last up to 7 years with higher utilization of health services

Orthopedics

- High margin, in demand
- Current pieces are fragmented both in care delivery and patient experience
- Comprehensive Care for Joint Replacement ("CCJR") CMS bundled payment here
- Comprehensive rotator cuff bundled program and total joint center are potential opportunities
- Explore demand for sports medicine and concussion clinics

Develop an Ambulatory Care Network (2016)

Create a network where every patient has access to primary care, urgent care, imaging, blood draw and specialists within 10 minutes of anywhere in our market

DEFINING PRINCIPLES

- Network of ambulatory services with access points throughout our service area
- Positioned to be consumer driven for “vertical” patients
- Primary Care, Urgent Care, Imaging, Lab and Specialist’s offices are the core
- Develop strong brand identity and customer experience
- Located in retail corridors

Develop an Ambulatory Care Network

SHORT TERM (1-2 YEAR) INITIATIVES

- Continue to open our access centers (Primary Care, Urgent Care, Imaging, Lab, Specialist Space) in key strategic areas
- Transform occupational medicine towards corporate wellness
- Complete a feasibility plan for an ambulatory pavilion connected to Saint Mary's Hospital
- Complete master partnership with NVRA with go--no go decision
- Optimize medical space throughout the health system

Develop an Ambulatory Care Network

LONG-TERM (3-5 YEAR) INNITIATIVES

- Establish 5-7 ambulatory care centers in the market including primary care, urgent care, imaging and blood draw
- If feasible, build an ambulatory care pavilion connected/adjacent to Saint Mary's Hospital
- Explore development of a Digestive Disorders Center including GI
- Explore development of a Medical Fitness and Wellness strategy in conjunction with physical and occupational therapy
- Explore development of a Women’s breast center
- Create a comprehensive Cardiac Center

EXHIBIT 6

GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP

Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

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EXECUTIVE SUMMARY

The Greater Waterbury Health Improvement Partnership led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2012. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Statistical Data Profile of Waterbury, Connecticut and surrounding cities
- Household Telephone Survey with 1,100 community residents
- Focus Group Discussions with 24 health care providers and 33 community residents
- Key Informant Interviews with 205 community leaders and partners
- Prioritization Session
- Hospital Implementation Plans
- Community Health Improvement Plan (CHIP)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Documentation

A final report of the CHNA was made public in September 2013 and can be found on the partner's websites. Hospital Implementation Plans, as well as a Community Health Improvement Plan (CHIP), were developed and adopted by each appropriate authority in September 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

The Greater Waterbury Health Improvement Partnership is made up of a group of not-for-profit organizations serving the residents of Waterbury, Connecticut and surrounding communities. The Greater Waterbury Health Improvement Partnership defined their current service area as the City of Waterbury and the surrounding communities served by Saint Mary's Hospital and Waterbury Hospital. The area encompasses southwest Connecticut and is relatively large with a population of approximately 313,000 residents. The geographic area was defined by primary service area (PSA) and secondary service area (SSA). The PSA is the area that the partnership predominantly serves and the hospitals main catchment area. It comprises all of Waterbury and has a population of approximately 110,000 residents. The SSA includes portions of the surrounding communities served by the two hospitals and has a population of approximately 203,000 residents. The conclusions drawn from the various research components focus on the primary service area, the town of Waterbury, Connecticut.

CHNA Partners

- The City of Waterbury
- Connecticut Community Foundation
- Saint Mary's Hospital
- StayWell Health Center
- Waterbury Department of Public Health
- Waterbury Hospital
- The United Way

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Waterbury, Connecticut and surrounding cities was compiled.

- A Household Telephone Survey was conducted with 1,100 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health

status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Qualitative Data:

- Six Focus Groups were held with 24 health care providers and 33 community residents in February 2013.

- Key Informant Interviews were conducted with 205 community leaders and partners between February and April 2013.

Research Partner

The Greater Waterbury Health Improvement Partnership contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from the household telephone survey
- Conducted focus groups with community members
- Conducted key informant interviews with community leaders and partners
- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The Greater Waterbury Health Improvement Partnership sought community input through focus groups with health care providers and community members, key informant interviews with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Additionally, language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Greater Waterbury Health Improvement Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, the Greater Waterbury Health Improvement Partnership prioritized community health issues and developed an implementation plan to address prioritized community needs.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in the Greater Waterbury Health Improvement Partnership service area.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Waterbury Department of Health, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

Secondary Data Profile Key Findings

This section serves as a summary of the key takeaways from the secondary data profile. A full report of the findings is available through the Greater Waterbury Health Improvement Partnership.

Demographic Statistics

According to U.S. Census Bureau estimates (2009-2011), the total population in Waterbury, Connecticut is 110,075, a decline of 2.55% since 2000. The majority of residents identify as White (58.2%), indicating a less diverse population when compared to peer cities, but a more diverse population when compared to all of Connecticut. Approximately 19% of residents identify as Black/African American and 30.1% identify as Hispanic or Latino. The primary spoken language is English, but 31.6% of residents speak a language other than English at home. The median age in Waterbury is 35.2, which denotes a younger population when compared to Connecticut, but an older population when compared to most peer cities (U.S. Census Bureau, 2012).

Table 1. Overall Population (2009-2012)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
White	78.6%	58.2%	32.2%	46.7%	48.6%	59.6%
Black/African American	9.8%	19.4%	37.2%	34.4%	34.5%	14.8%
Asian	3.8%	1.7%	2.5%	4.9%	3.6%	8.05%
Two or more races	2.3%	5.6%	4.0%	2.9%	1.9%	1.7%
Hispanic or Latino (of any race)[b]	13.0%	30.1%	42.4%	26.3%	36.7%	24.4%

Source: U.S. Census Bureau, 2012

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race, for example, White Hispanic

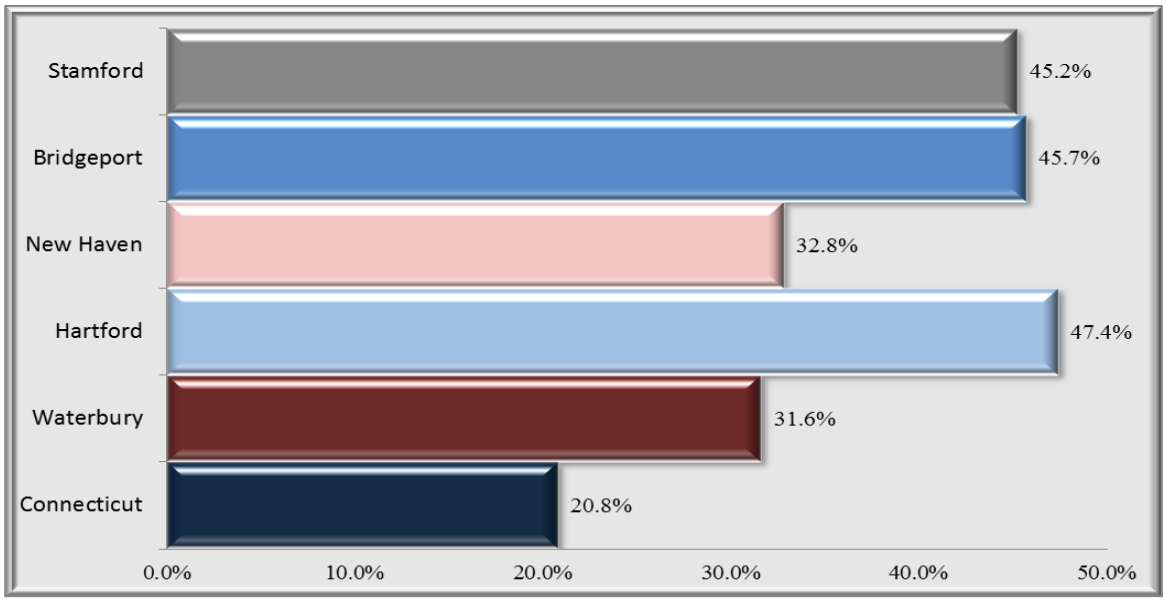


Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

Waterbury is comprised primarily of family households (63.2%), which are defined as more than one person living together, either as relations or as a married couple. These households and nonfamily households are less likely to live in owner-occupied units (49.6%) compared to Connecticut (68.9%), but more likely to live in owner-occupied units compared to most peer cities. The median value for owner-occupied units is $164,000, which is lower than the median value across the state ($293,100) and all peer cities (U.S. Census Bureau, 2012).

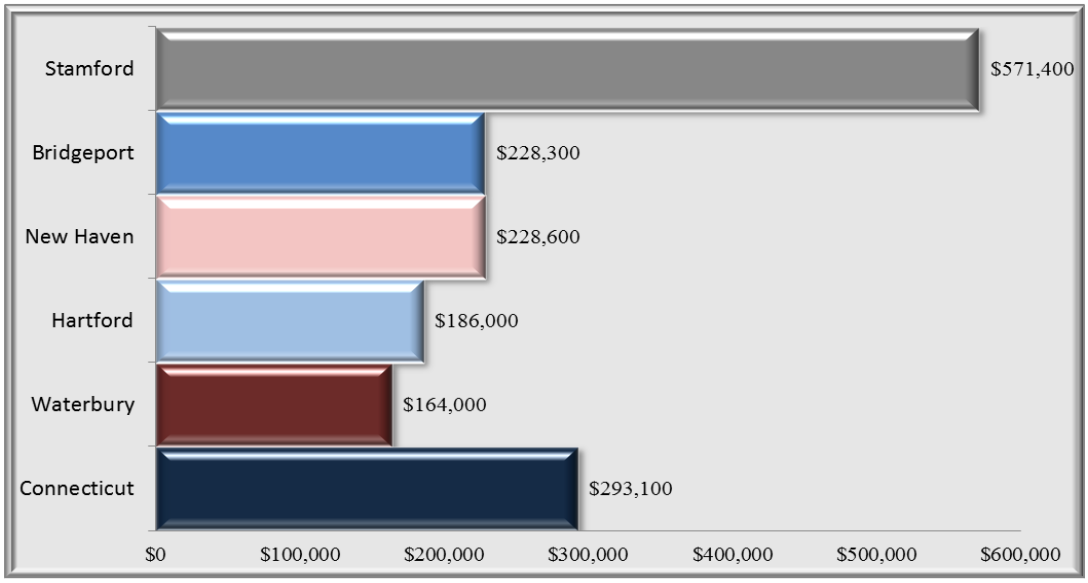


Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

Approximately 40% of Waterbury residents aged 15 years and over have never been married. This is greater than the percentage across Connecticut (31.8%), but lower than the percentage across most peer cities. Among those residents who have been married, a higher percentage are divorced (11.6%) compared to Connecticut (10.2%) and all peer cities (U.S. Census Bureau, 2012).

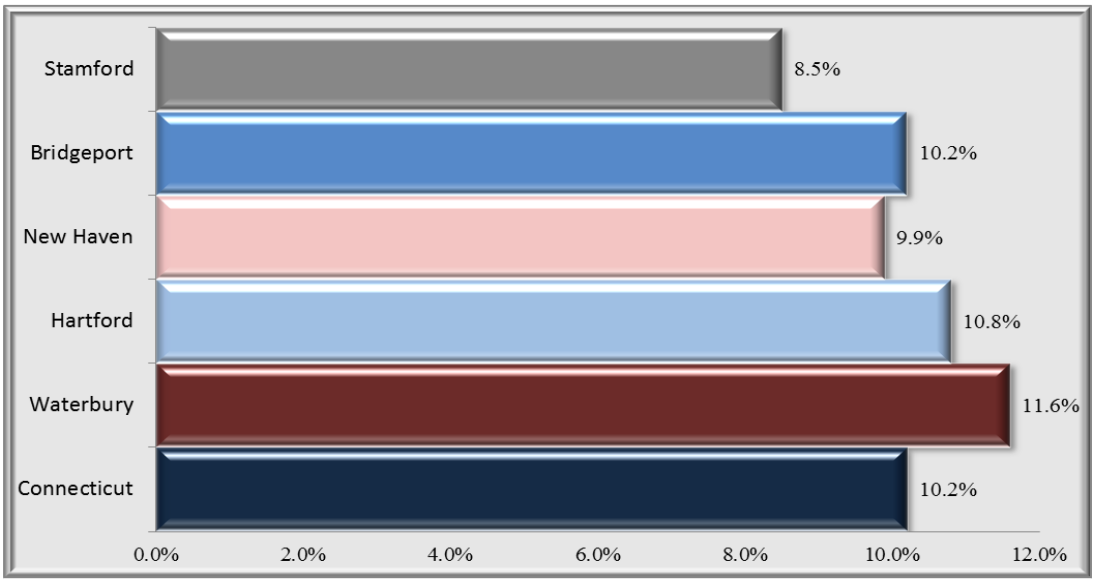


Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

The median income for households and families across Waterbury ($41,499 and $49,059 respectively) is lower than across all of Connecticut ($69,243; $86,395). However, it is higher when compared to most peer cities. The same trend is true of the median income for workers. The percentage of families and individuals living in poverty in the past 12 months is higher in Waterbury than in all of Connecticut (U.S. Census Bureau, 2012). More residents in Waterbury are also enrolled in social assistance programs like Temporary Family Assistance and Medicaid when compared to Connecticut and most peer cities. Between the years 2011 and 2012, 28.2% of residents were enrolled in Temporary Family Assistance and 38.1% were enrolled in Medicaid. Medicaid enrollment has been on the rise across all of Connecticut and its cities since 2006 (Connecticut Department of Social Services, n.d.).

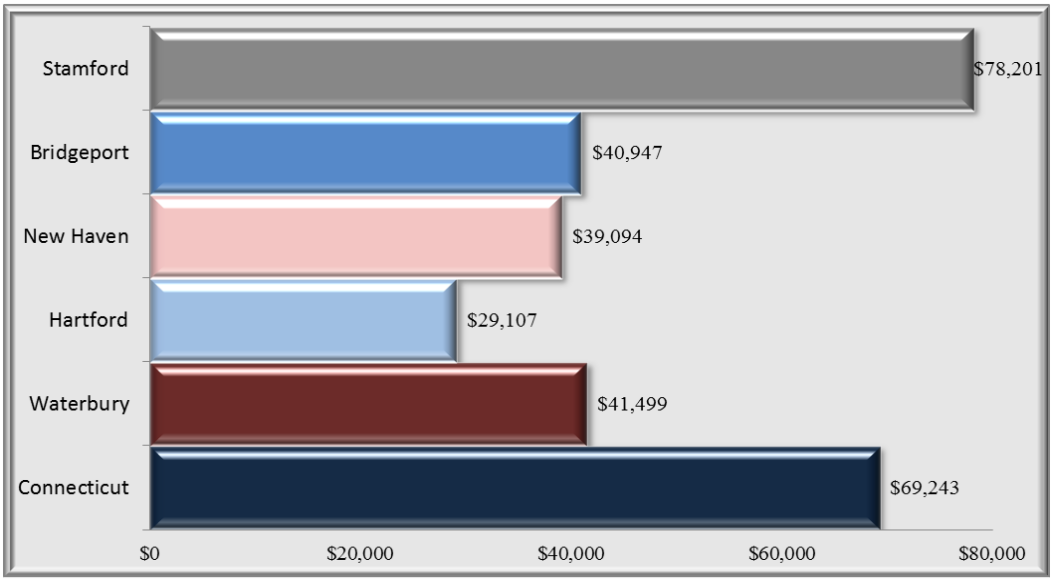


Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

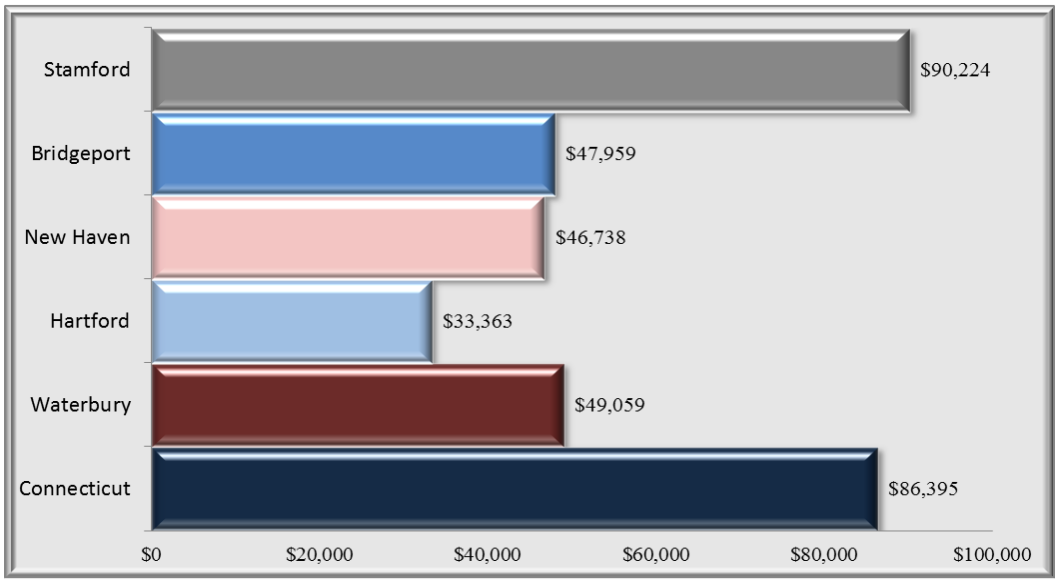


Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Families	6.7%	17.1%	29.9%	20.8%	18.0%	7.5%
With related children < 18 years	10.8%	26.3%	39.3%	30.0%	25.3%	11.6%
With related children < 5 years	12.5%	22.4%	46.1%	21.3%	20.6%	12.7%
Married couple families	2.3%	5.6%	9.3%	7.4%	7.3%	3.4%
With related children < 18 years	3.1%	7.7%	12.1%	11.2%	10.7%	4.5%
With related children < 5 years	3.4%	7.5%	11.3%	9.2%	6.0%	3.8%
Families with female householder, no husband present	22.9%	35.5%	44.5%	36.9%	34.1%	22.1%
With related children < 18 years	30.8%	44.3%	51.6%	44.9%	40.8%	30.4%
With related children < 18 years	40.1%	47.7%	60.8%	42.7%	41.1%	35.8%
All people	9.5%	20.6%	32.9%	26.3%	21.9%	11.0%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2012), the unemployment rate in Waterbury is 12.7%. This rate is higher than the unemployment rate across Connecticut (8.5%). It is favorable or comparable to peer cities. Of the residents who are employed, the majority work in management, business, science, and arts and are private wage and salary workers. A notable percentage of residents are also employed in a service occupation.

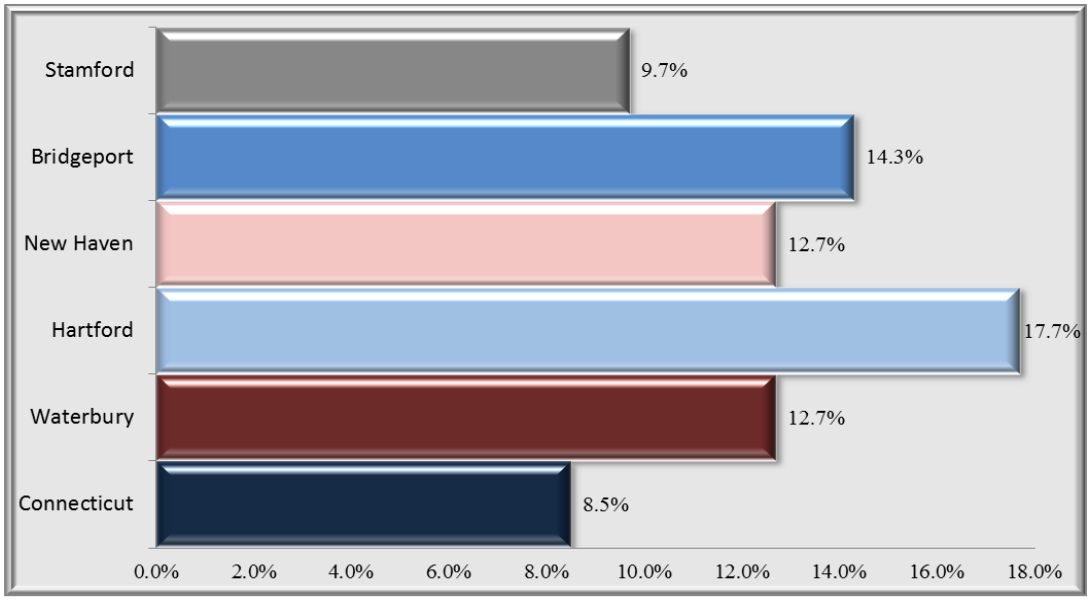


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. High school and higher education graduation rates are lower in Waterbury (78.7% and 17.2% respectively) than in Connecticut (88.6% and 35.7% respectively) and comparable to peer cities (U.S. Census Bureau, 2012).

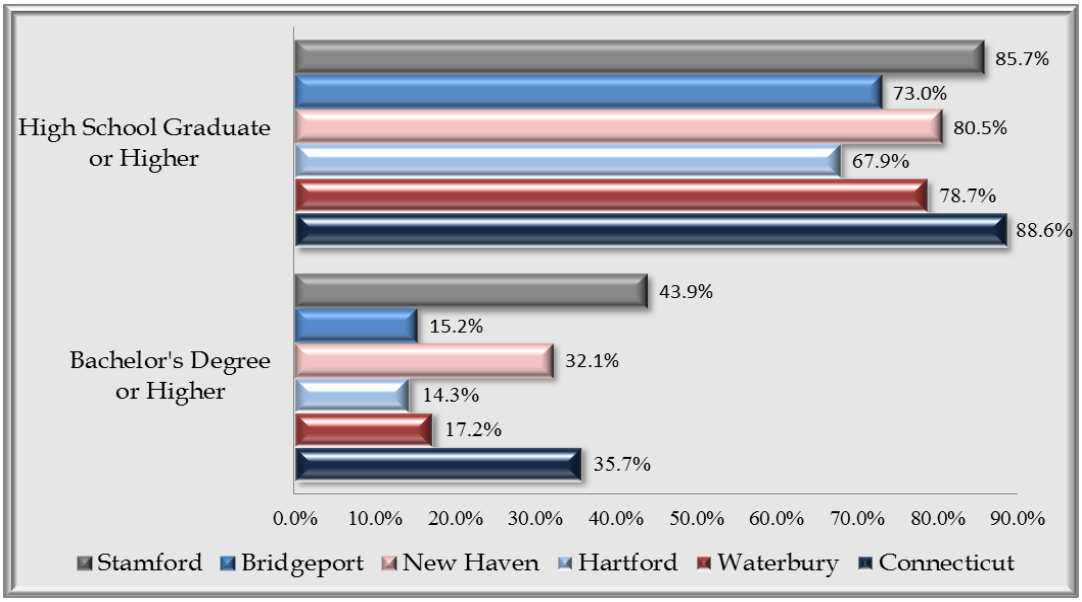


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

Health Status Indicators

Mortality Rates

The overall crude mortality rate for Waterbury, Connecticut is 9.2 per 1,000. This is higher than the mortality rate for Connecticut (8.1 per 1,000) and peer cities. A contributing factor to the higher overall mortality rate in Waterbury compared to peer cities may be its slightly older population. However, this does not apply when comparing to all of Connecticut as the state has a higher median age (Connecticut Department of Public Health, 2011).

The graphs below detail the age-adjust deaths rates per 100,000 for three of the leading causes of death in Waterbury. For all causes, Waterbury has a higher death rate than Connecticut. For chronic lower respiratory disease, Waterbury has a higher death rate (37.2) than Connecticut and all peer cities. Death rates due to heart disease and cancer in Waterbury are comparable to peer cities, but are still of concern as the top two leading causes of death (Connecticut Department of Public Health, 2011).

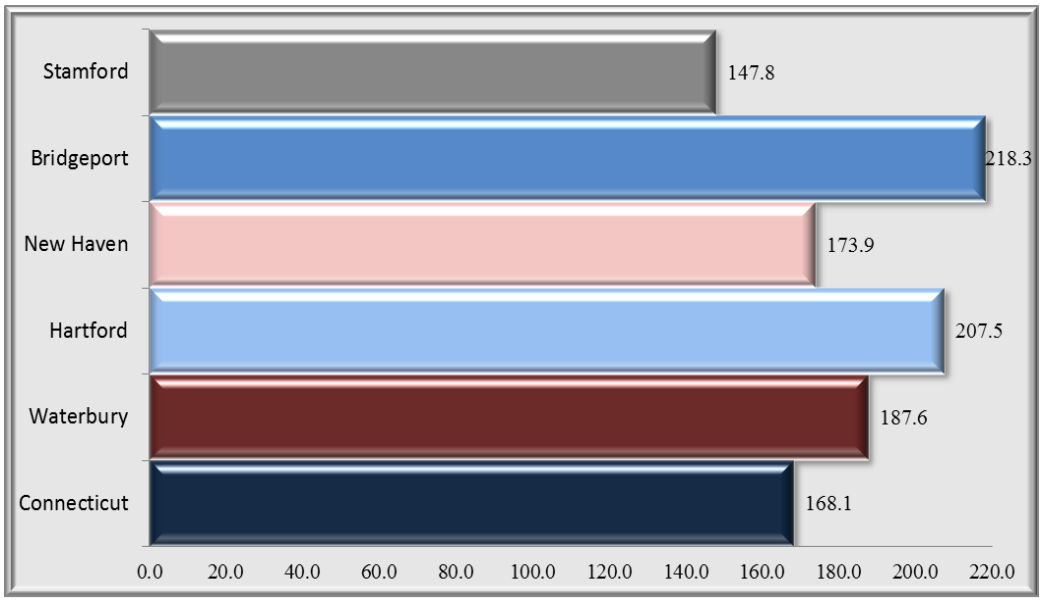


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

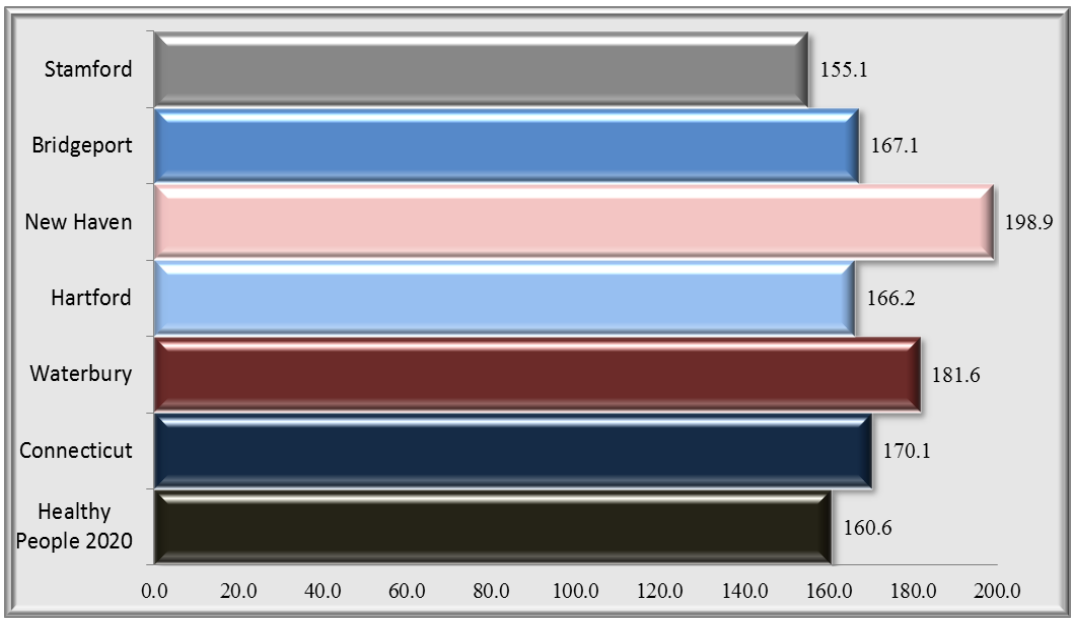


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

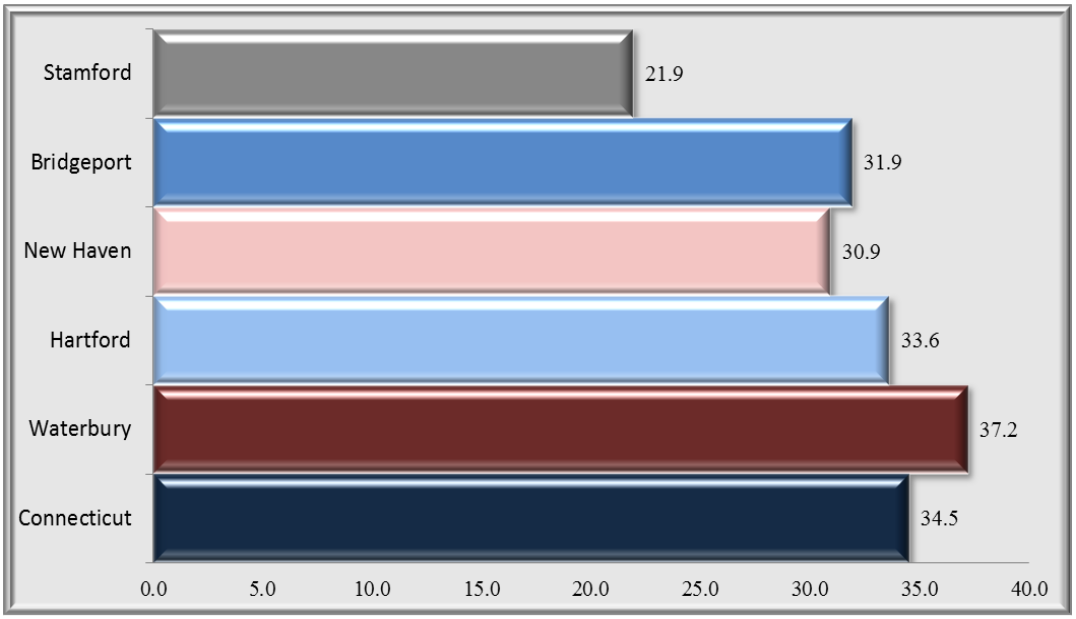


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

Maternal & Infant Health

The birth rate per 1,000 in Waterbury (15.7) is higher when compared to Connecticut (11.0), but similar to or lower than peer cities. Of the births that occur, 4.9% are to mothers less than 18 years of age and 14.5% are to mothers less than 20 years of age. These percentages are higher than what is seen across Connecticut (2.0% and 6.8% respectively) and all peer cities, excepting Hartford. The majority of teenage births are to mothers of Black and/or Hispanic race/ethnicity. Overall, the findings for teenage birth for the most recent year of data are negative, but births to teenagers less than 18 years of age have been trending downwards since 2005 (Connecticut Department of Public Health, 2011).

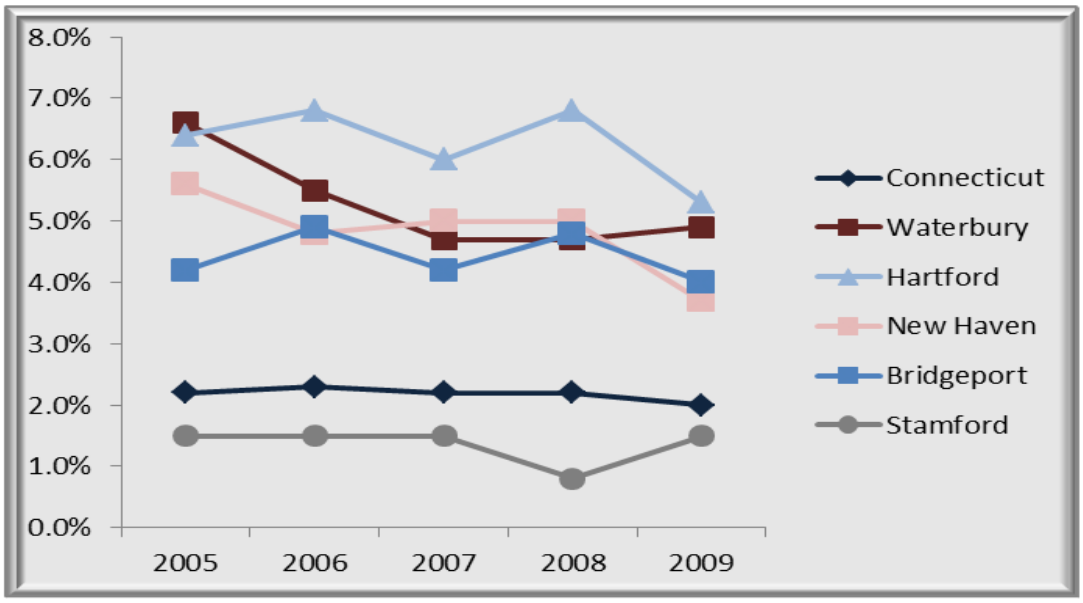


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

A total of 16 infant deaths occurred in Waterbury for a rate of 9.5 per 1,000 live births. This is higher when compared to Connecticut (5.6) and the Healthy People 2020 goal (6.0). The majority of infant deaths was among White infants (11 deaths, rate of 8.6) and occurred in the neonatal phase (within the first 27 days after birth). Seven Hispanic infant deaths also occurred in Waterbury for a rate of 10.4. This compares to a rate of 7.1 across all of Connecticut. In general, infant mortality has trended upwards in Waterbury since 2005 (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Related to infant mortality is birth weight. The percentage of infants born with low birth weight in Waterbury (10.0%) is higher when compared to Connecticut (8.1%), the Healthy People 2020 goal (7.8%), and every peer city except Hartford (10.5%). In particular, the percentage of Black infants born with low birth weight (14.6%) and very low birth weight (4.1%) is notably higher compared to Connecticut (12.0%; 3.2%) and all peer cities. Low birth weight has been on the rise in Waterbury since 2005, particularly for Black infants (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Despite primarily negative findings related to teenage birth, infant mortality, and birth weight, Waterbury mothers are more likely to receive adequate and intensive prenatal care than mothers across Connecticut. This is true for mothers of White, Black, and Hispanic race/ethnicity. Mothers receiving late or no prenatal care has been on the decline in Waterbury since 2005 (Connecticut Department of Public Health, 2011).

Sexually Transmitted Illnesses

Sexually transmitted illness rates per 100,000 are notably higher in Waterbury than in Connecticut, particularly for chlamydia and gonorrhea. The chlamydia rate is 720.5 in Waterbury compared to 344.9 in Connecticut and the gonorrhea rate is 225.9 in Waterbury compared to 72.6 in Connecticut. The Waterbury rates are more favorable compared to peer cities. The chlamydia rate alone is as high as 1,220.3 in New Haven and 1,513.8 in Hartford (Connecticut Department of Public Health, n.d.). The following chart illustrates this difference.

Table 3. Sexually Transmitted Illness Cases per 100,000 (2009, 2010)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
HIV	11.4	17.2	54.5	31.6	33.3	11.4
Gonorrhea	72.6	225.9	403.0	363.3	239.6	37.2
Chlamydia	344.9	720.5	1,513.8	1,220.3	863.8	268.5
Primary/Secondary Syphilis	1.8	1.9	6.4	3.2	4.4	2.5

Sources: Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2010 data

Mental Health Statistics

The suicide rate is considered to be an indicator of the mental health status of an area. The suicide rate per 100,000 in Waterbury is 8.6, which meets the Healthy People 2020 goal of 10.2, but is higher than Connecticut (7.8) and all peer cities (5.5 – 8.4). The suicide rate is a negative finding, but it should not be considered an all-encompassing indication of the mental health status of Waterbury. Additional indicators from the household telephone survey, focus groups, and key informant interviews should be considered for a more comprehensive understanding (Connecticut Department of Public Health, n.d. & Healthy People 2020, 2012).

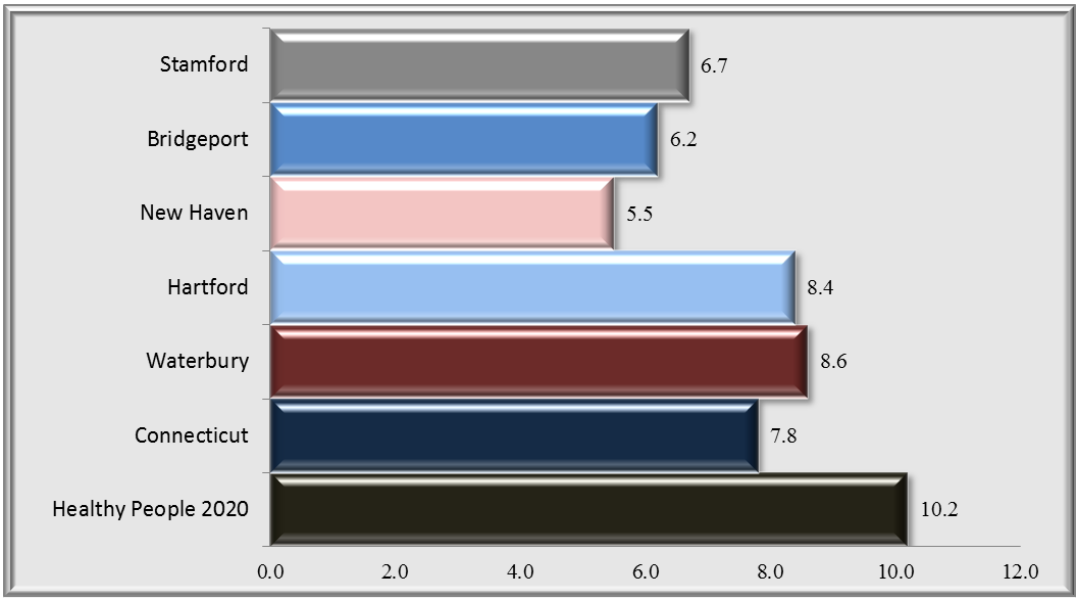


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Cancer Statistics

Cancer affects Waterbury residents at a rate of 484.3 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 484.3 is similar to or lower than that of Connecticut and peer cities. However, lung cancer disproportionately affects Waterbury residents at a rate of 81.2 compared to 74.3 across Connecticut and a range of 45.0 – 67.5 across all peer cities (Connecticut Department of Public Health, n.d.). The following chart depicts incidence rates for all reported cancer types.

Table 4. Cancer Incidence by Site per 100,000 (2007)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	155.6[a]	134.8[a]	83.7[a]	118.9[a]	107.8[a]	155.8[a]
Colorectal	51.3	51.3	33.7	37.9	43.2	65.0
Lung	74.3	81.2	45.0	55.7	64.4	67.5
Prostate	173.3[a]	76.2[a]	119.5[a]	116.8[a]	128.6[a]	178.8[a]
All sites	**561.6**	**484.3**	**335.6**	**445.4**	**443.3**	**534.3**

Source: Connecticut Department of Public Health, n.d.
[a]Rates based on 2010 population counts

In contrast to the overall cancer incidence rate, the overall cancer mortality rate is higher in Waterbury than in Connecticut and all but one peer city, New Haven. The mortality rate per 100,000 for all cancer types is 181.6 in Waterbury compared to 170.1 across Connecticut and a range of 155.1 – 167.1 across Bridgeport, Stamford, and Hartford. Lung cancer presents as an area of concern again as the mortality rate for this condition is notably higher in Waterbury

(53.5) compared to Connecticut (45.0), Healthy People 2020 (45.5), and all peer cities (36.5 – 44.1) (Connecticut Department of Public Health, n.d.).

Table 5. Cancer Mortality by Site per 100,000 (2005 - 2009)

	HP 2020	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	20.6	N/A	12.8	11.0	17.9	14.5	11.7
Colorectal	14.5	14.6	15.9	16.4	18.5	13.8	12.8
Lung	45.5	45.0	53.5	42.2	44.1	43.3	36.5
Prostate	21.2	N/A	7.7	8.9	11.8	7.2	9.1
Skin	N/A	2.6	N/A	N/A	N/A	N/A	N/A
All sites	160.6	170.1	181.6	166.2	198.9	167.1	155.1

Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Environmental Health Statistics

The environment that residents live, work, and play in can have a profound impact on their health. An indicator of the environmental health of an area is the prevalence of asthma. In Waterbury, the rate per 100,000 for emergency department visits due to asthma is 144.0 in adults 18 years and over and 197.3 in children under 18 years. This is notably higher than Connecticut's rates for adults and children (44.7 and 61.3 respectively) and most peer cities. Among adults in Waterbury, females, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma. Among children in Waterbury, males, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma (Connecticut Department of Public Health, 2009).

Table 6. Emergency Department Visits due to Asthma per 10,000 (2001 – 2005)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Population 18 +	44.7	144.0	182.8	108.8	126.7	41.5
Population <18	61.3	197.3	241.7	213.8	165.9	80.8

Source: Connecticut Department of Public Health, 2009

Another indicator of the environmental health of an area is the presence of food deserts, which are defined by Census tracts. Food deserts are areas that have little or no access to fully-stocked grocery stores that offer fresh, healthy, and affordable foods. In Waterbury, a number of census tracts have large populations living in food deserts. However, census tract 9009352400 is of particular concern. It has the highest percentage of residents living in a food desert across four out of the five reported categories (United States Department of Agriculture, 2010).

Table 7. Food Deserts by Census Tracts in Waterbury, Connecticut (2012)

	Population with low access to nutritious food sources	Population with low income and low access	Population 0-17 years with low access	Population 65+ years with low access	Population with no vehicle and low access
9009352400	100.0%	12.7%	31.6%	9.7%	16.4%
9009352300	21.3%	2.5%	5.2%	2.5%	3.4%
9009352200	55.1%	18.5%	24.2%	2.9%	14.2%
9009352100	33.7%	5.4%	9.5%	4.7%	3.6%
9009351800	57.7%	3.6%	10.8%	9.5%	3.7%
9009351500	45.9%	5.6%	11.7%	7.4%	7.0%
9009352800	33.4%	2.8%	11.4%	2.4%	4.3%

Source: United States Department of Agriculture, 2010

Secondary Data Profile Summary of Findings

The secondary data profile provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. In Waterbury, the median income for households and families is higher; fewer residents live in poverty when compared to most peer cities. Residents are also less likely to rely on social assistance programs like Medicaid and State Administered General Assistance medical. In terms of health outcomes, Waterbury has lower rates of stroke mortality and sexually transmitted illness incidence. Waterbury has a number of strengths and assets, but it also has some areas to improve upon. In particular, Waterbury residents have more respiratory health issues and issues related to maternal and child health. In relation to respiratory health, residents are more likely to have visited an emergency department for asthma complications and to have died from lung cancer and chronic lower respiratory disease. Related to maternal and child health, the infant mortality rate is higher, infants are more likely to be born with low or very low births weight, and the number of teenage pregnancies is higher. Additional areas of concern in Waterbury are the suicide rate and food deserts, particularly in census tract 9009352400.

HOUSEHOLD TELEPHONE SURVEY OVERVIEW

Background

A statistical Household Telephone Survey was conducted based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, conducted annually at the state level. The survey assesses self-reported health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

For the Waterbury study, trained interviewers conducted telephone interviews between May and June 2013 by trained interviewers. Participants were randomly selected for participation based on a statistically valid sampling frame that included landline and cell phone telephone numbers. Only respondents who were at least 18 years of age and lived in a private residence were included in the study. A total of 1,121 individuals who reside within specific Zip codes served by the Greater Waterbury Health Improvement Partnership were interviewed by telephone. Select participant demographics are included in Appendix C.

The customized survey tool consisted of approximately 100 factors selected from BRFSS tool. A few customized questions were added to gather information about health issues specific to the service area. Depending upon interviewees' responses, interviews ranged from approximately 15 to 30 minutes in length.

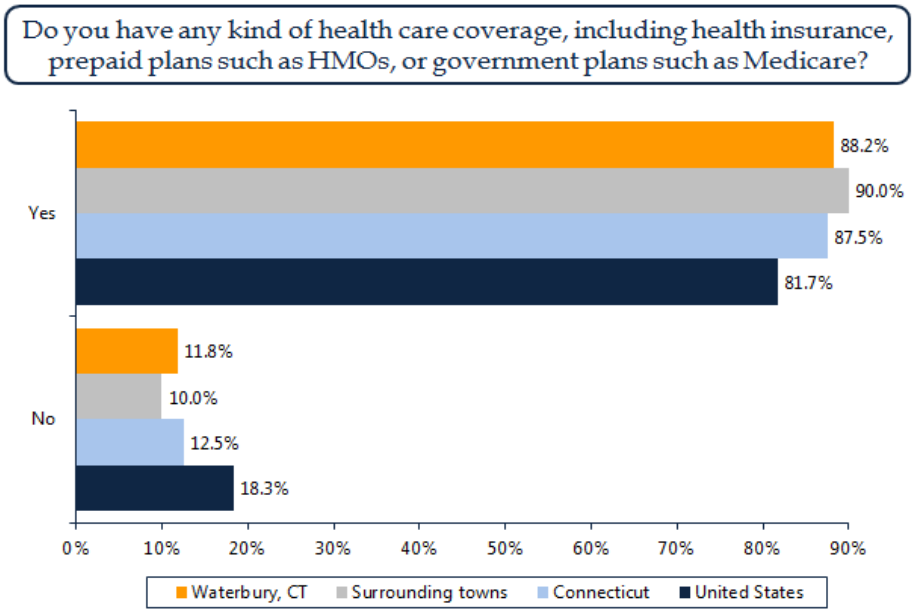
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

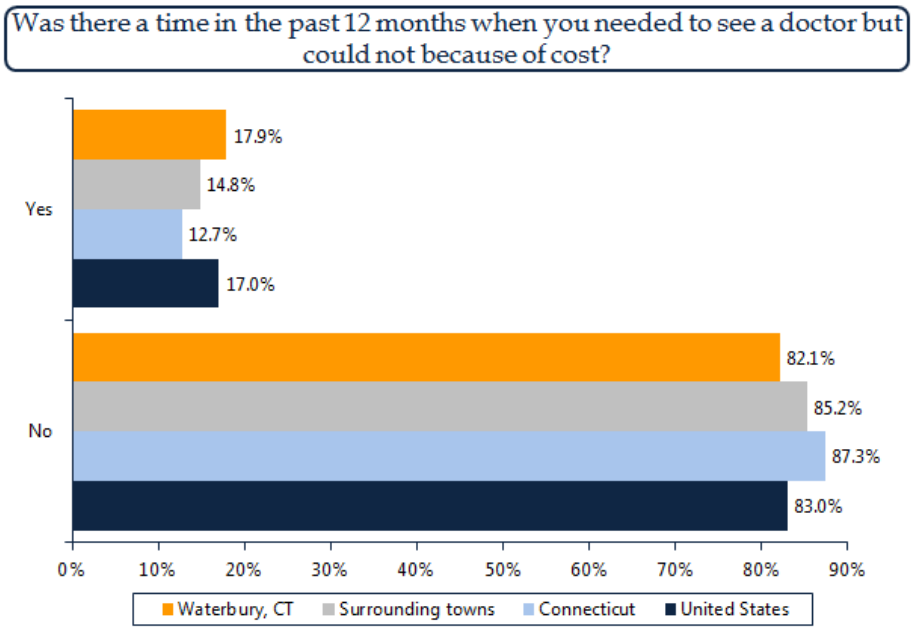
Household Telephone Survey Key Findings

The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

Access to Health Care

Overall, residents of Waterbury are just as likely or more likely to have health care coverage (88.2%) and at least one person who they think of as their personal doctor or health care provider (84.1%) when compared to the state (87.5%; 85.2%) and the nation (81.7%; 78.0%). Local residents are also more likely to have received a routine checkup within the past year (76.6%) compared to the state (70.4%) and the nation (66.9%). Despite primarily positive findings regarding health insurance and access to primary care, residents of Waterbury still cite the cost of care as a barrier. Nearly 18% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This may be an indicator that out-of-pocket expenses that are not covered by insurance (e.g. copays) are preventing residents from seeking care when they need it.

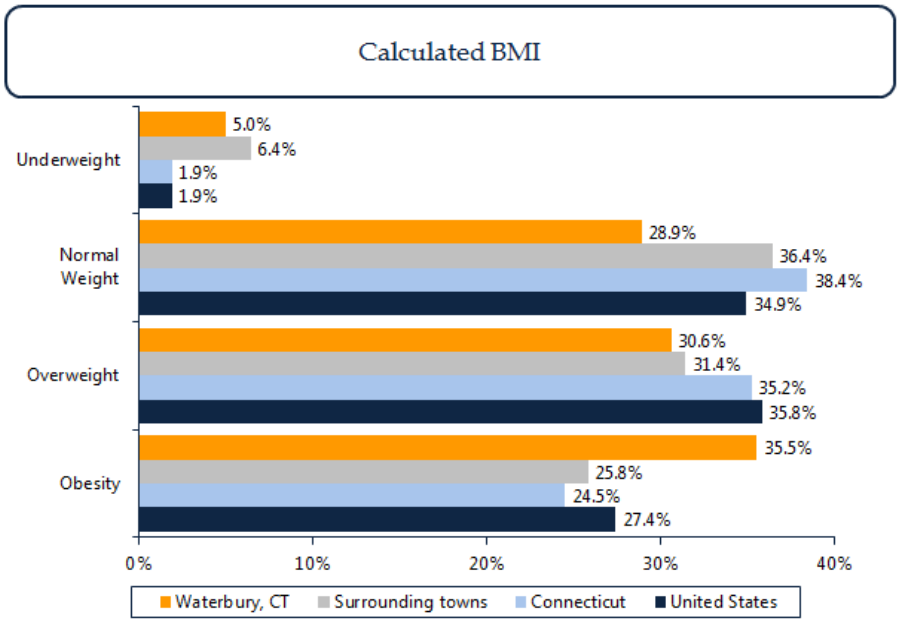




Health Risk Factors

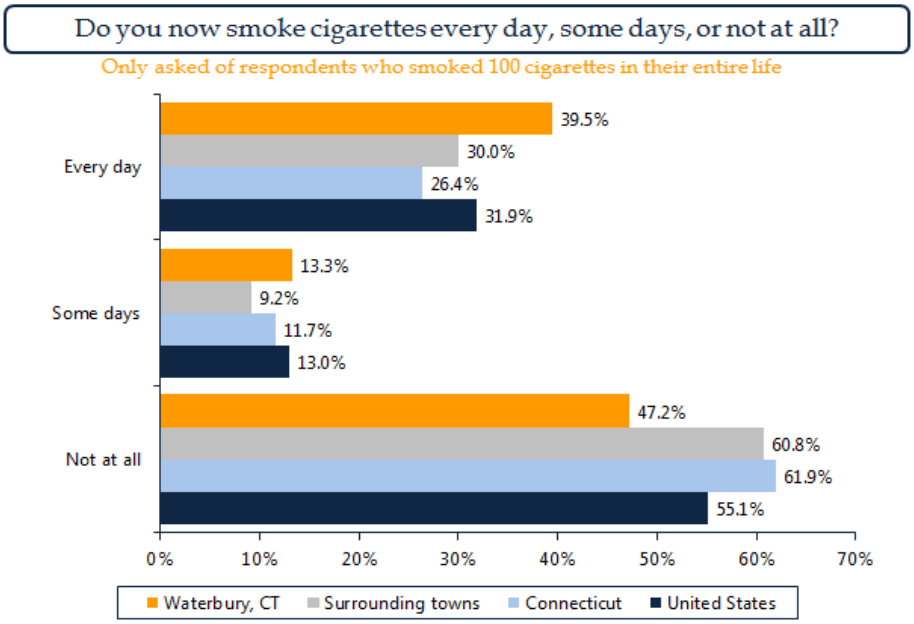
Obesity & Physical Activity

Obesity and its connection to serious medical conditions has become a national concern. In the latest BRFSS study, 63.2% of the nation and 59.7% of Connecticut was considered overweight or obese. Waterbury surpasses both with 66.1% of respondents considered overweight or obese and 35.5% considered obese. In addition, fewer respondents (68.9%) reported engaging in physical activity during the past month compared to the state (74.5%) and the nation (74.3%).

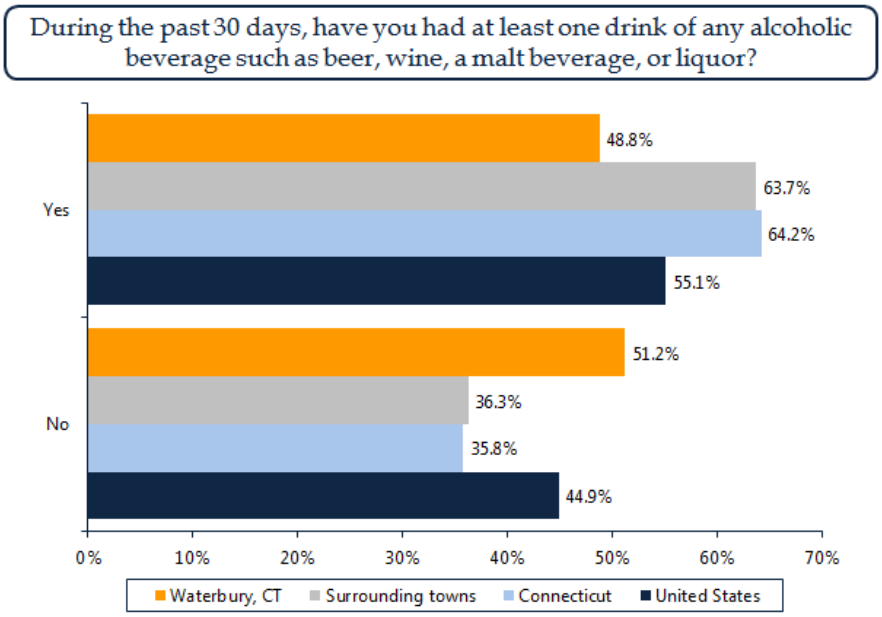


Tobacco & Alcohol Use

Tobacco use is a concern in Waterbury for both the proportion of residents who initiate smoking and the proportion who continue to smoke on a daily basis. More than half (51.1%) of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 45.0% across the state and 44.8% across the nation. In addition, more than half (52.8%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (38.1%) and the nation (44.9%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months.



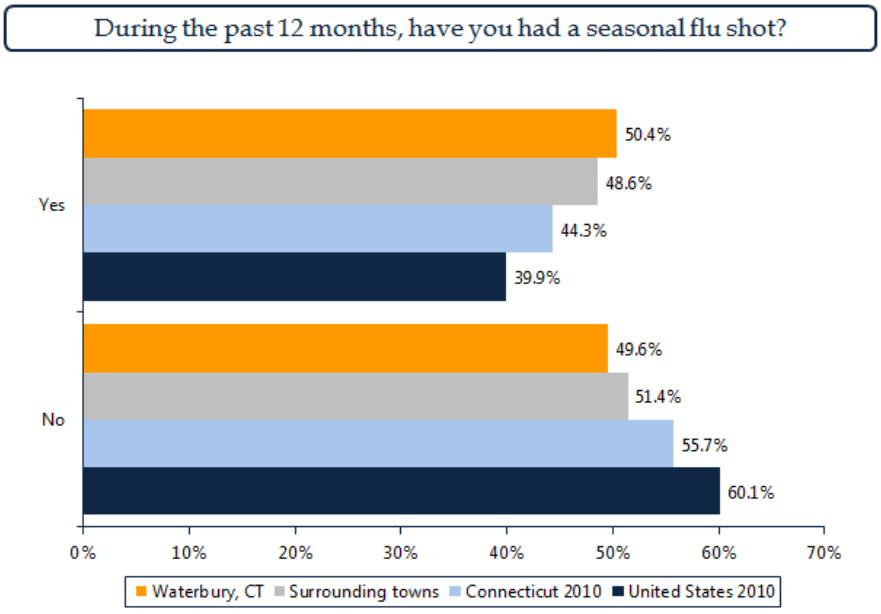
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.



Preventive Health Practices

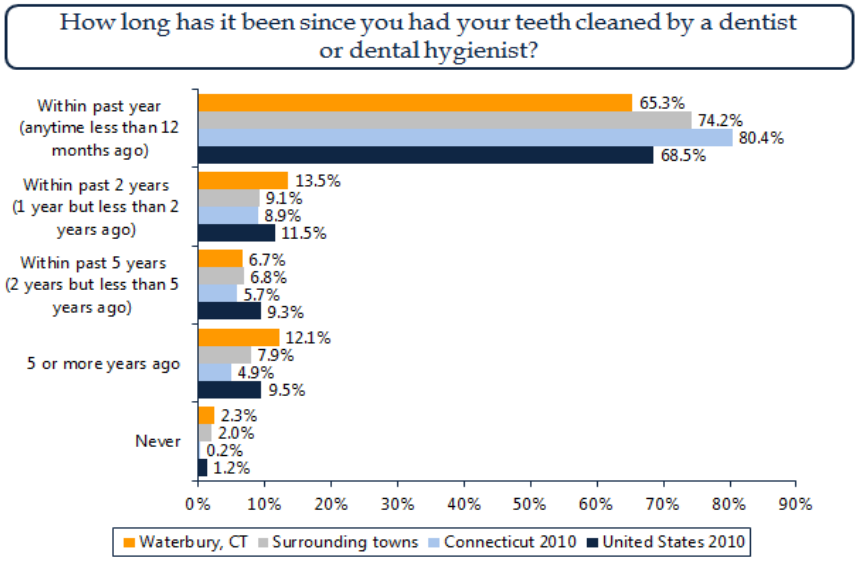
Immunizations

A positive finding among Waterbury respondents is the prevalence of immunizations. In the past 12 months, 51.8% of respondents received a flu vaccine either as a shot or a nasal spray compared to 45.2% in Connecticut and 41.3% in the nation. In addition, 35.5% received a pneumonia shot compared to 30.9% in Connecticut and 30.6% in the nation.

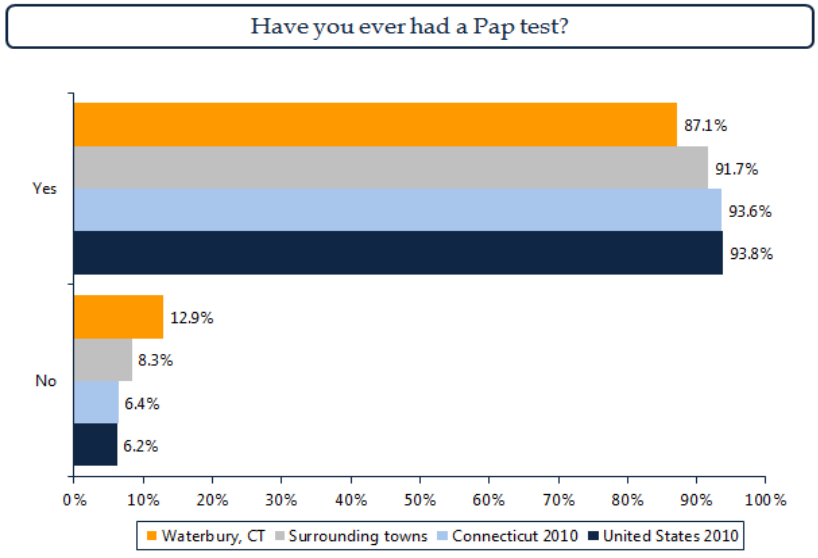


Screenings

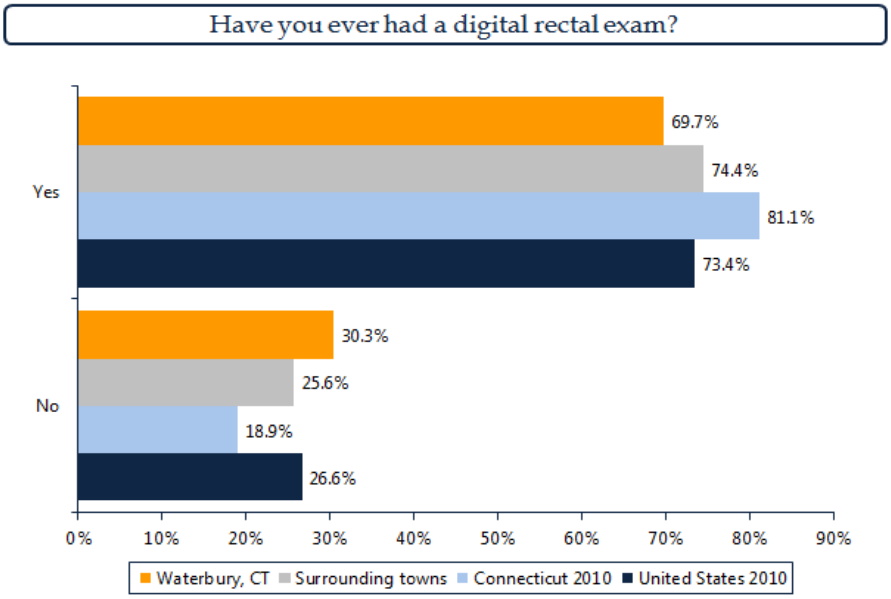
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents are also less likely to have had their teeth cleaned (65.3%) within the past year when compared to both the state (80.4%) and the nation (68.5%).



Female preventative screenings are also less prevalent among Waterbury residents. Women are less likely to have ever received a mammogram, clinical breast exam, or Pap test when compared to women across Connecticut and the nation. The percentage of Waterbury women receiving a Pap test is of particular concern as only 87.1% have ever had one compared to 93.6% in Connecticut and 93.8% in the nation. The percentage of women receiving clinical breast exams (87.8%) is also concerning when compared to all of Connecticut (92.4%).



Men ages 39 and older have a greater risk for prostate cancer and should receive regular diagnostic screenings. Male respondents in Waterbury are more likely to have had one of the suggested screenings, a prostate-specific antigen test (57.5%), when compared to men across the nation (51.1%). However, they are less likely to have the second suggested screening, a digital rectal exam (69.7%), when compared to men across Connecticut (81.1%) and the nation (73.4%). In addition, of the men who have had a digital rectal exam, fewer had it within the past year. This is a potential health concern since male respondents in Waterbury are more likely to have prostate cancer (6.0%) when compared to the nation (3.5%).



Colorectal cancer can be screened for through home blood stool tests and sigmoidoscopies/ colonoscopies. Waterbury respondents are slightly more likely to have had a sigmoidoscopy/ colonoscopy when compared to the nation, but notably less likely to have had a home blood stool test (27.7%) when compared to the nation (45.4%). Of those respondents who have had a home blood stool test, a large proportion last had one five or more years ago (35.0%).

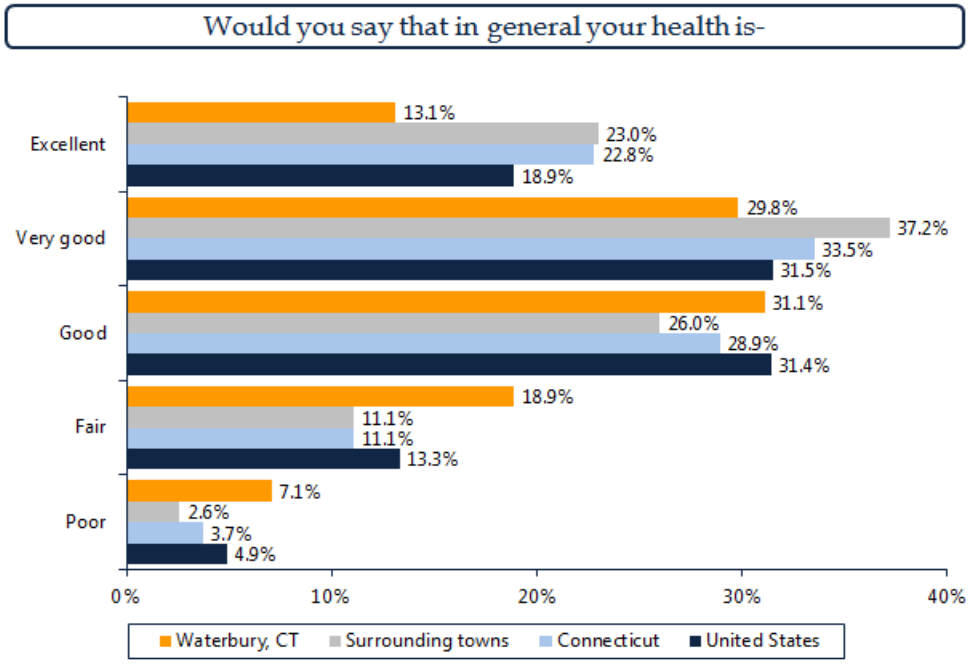
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high risk behaviors. Approximately 7% of Waterbury respondents said that high risk situations like intravenous drug use and sexually transmitted diseases apply to them. This compares to 3.6% across Connecticut and 3.8% across the nation.

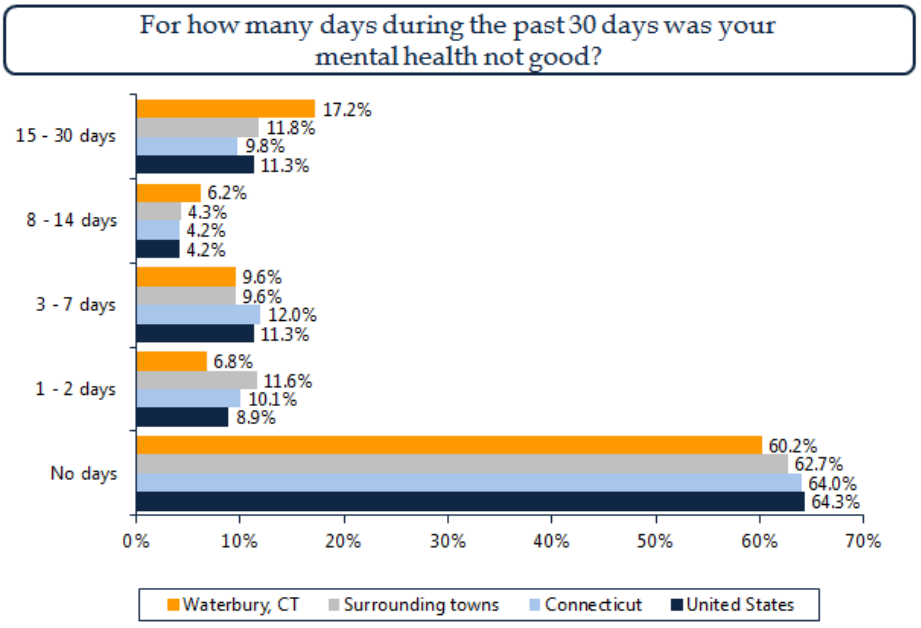
Health Status & Chronic Health Issues

Physical & Mental Health

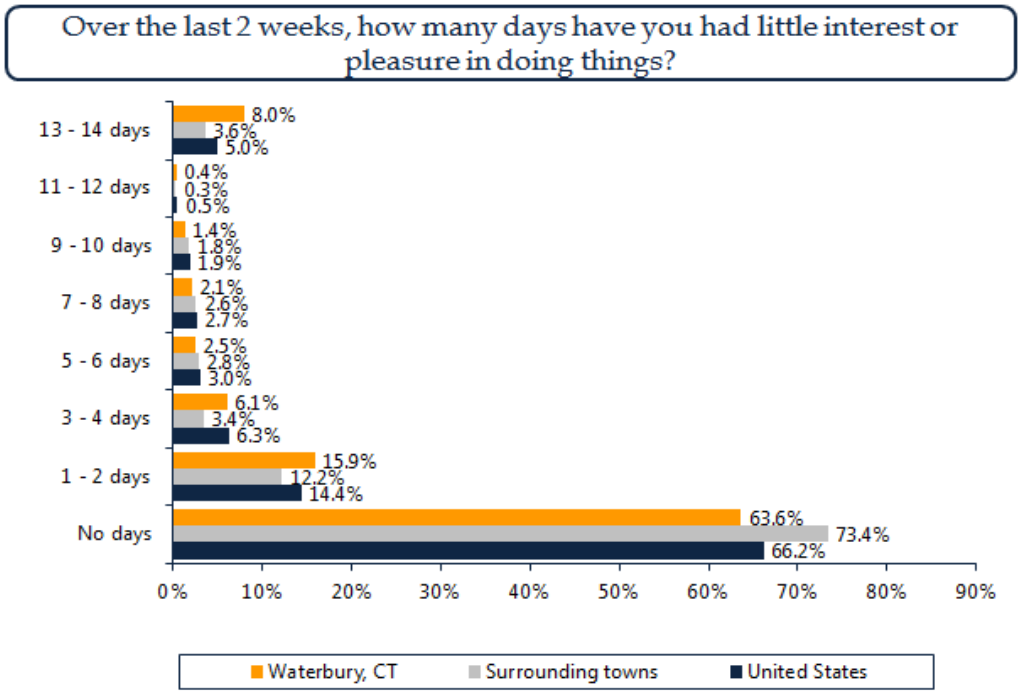
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

the nation (18.9%). In addition, during the past 30 days, 40.8% of respondents said that they had at least one day of poor physical health and 39.8% said that they had at least one day of poor mental health. Of particular concern is the 17.2% of respondents who said that they had 15 – 30 days of poor mental health during the past 30 days. This compares to 9.8% across Connecticut and 11.3% across the nation. The combination of poor physical and mental health days kept 45.3% of respondents from doing their usual activities on at least one of the past 30 days.





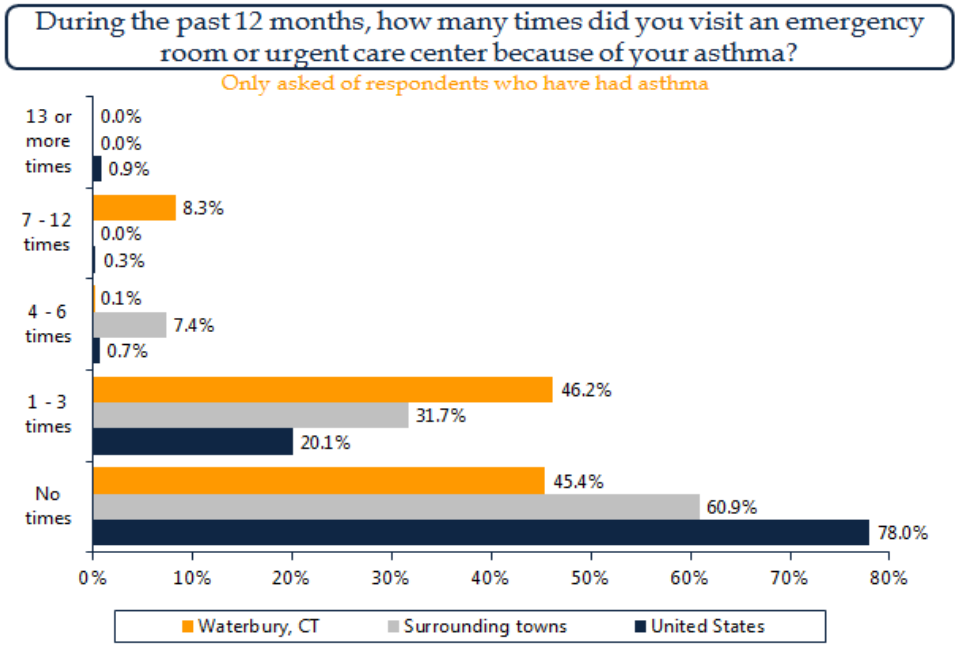
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 19.7%. This compares to 16.7% across the nation. Over the last two weeks, 36.4% of respondents had little interest or pleasure in doing things and 34.3% felt down, depressed, or hopeless. A positive finding is that more respondents (16.4%) are taking medicine or receiving treatment from a health professional for their mental health condition when compared to the nation (12.5%).



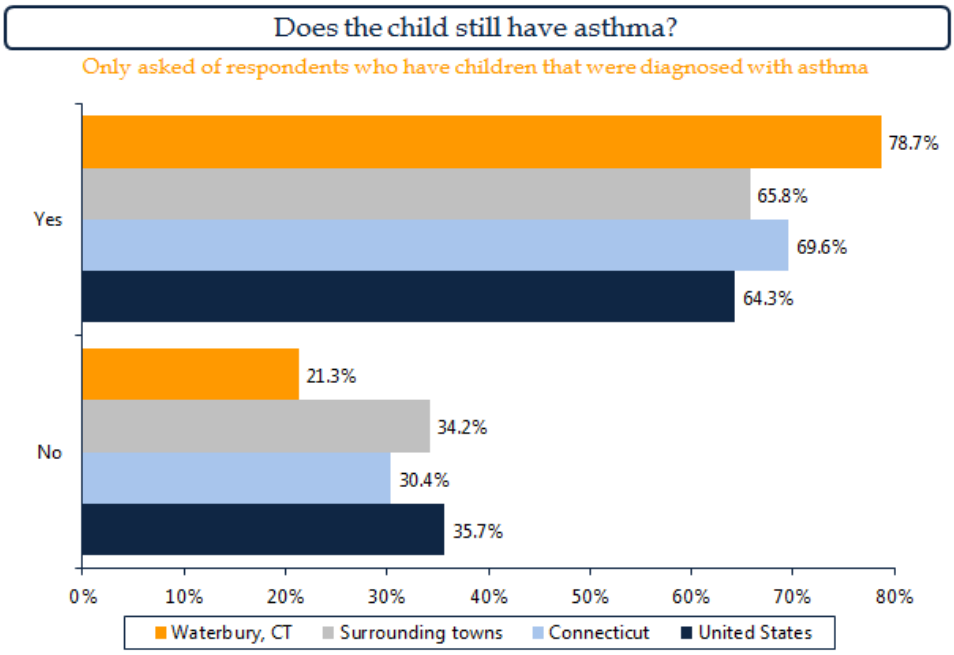
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the nation.

Chronic Health Issues

A number of chronic conditions are of concern in Waterbury, including asthma, cardiovascular disease, and diabetes. Approximately 22% of Waterbury respondents had been told that they have asthma. This compares to 14.8% in Connecticut and 13.5% in the nation. Additional data also suggests that asthmatics in Waterbury are not managing their condition as well. A higher proportion have had an asthma attack (59.2%) and visited an emergency room or urgent care center in the past year (54.6%) when compared to the nation (43.0%; 22.0%). A higher proportion has also been unable to carry out their usual activities because of their asthma (39.5%) when compared to the nation (23.8%).

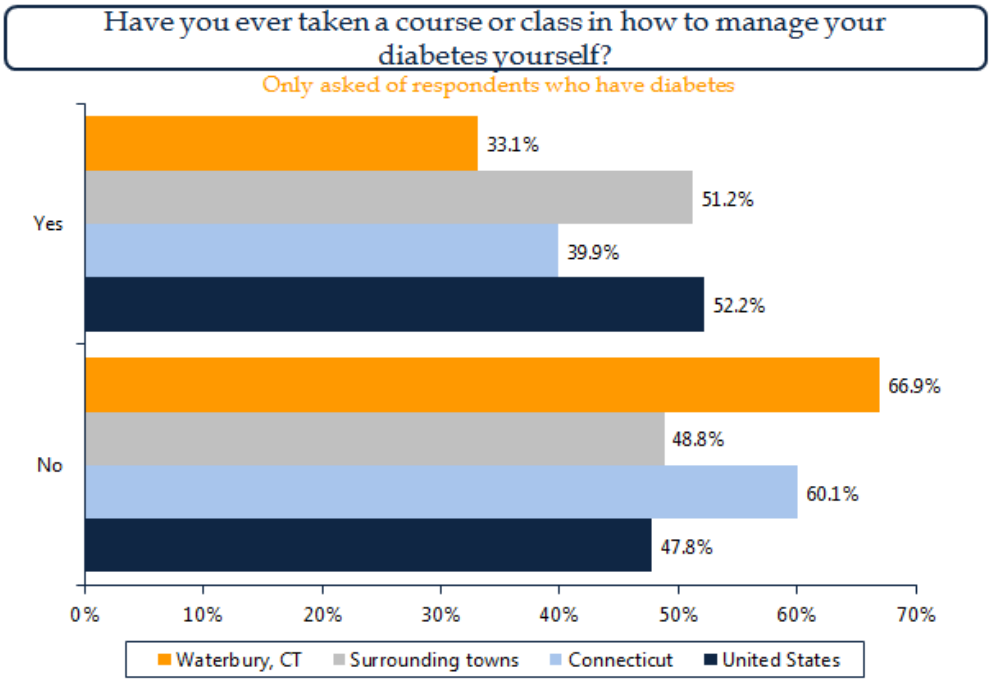


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



Residents in Waterbury are more likely to have cardiovascular health issues like heart attacks (6.6%), angina or coronary heart disease (5.9%), and stroke (5.4%). A contributing factor (other than obesity and lack of physical activity) may be high blood pressure. A higher proportion of Waterbury residents have high blood pressure (33.6%) when compared to Connecticut (29.7%) and the nation (31.6%) and fewer are taking medicine for it.

A higher proportion of residents in Waterbury have been diagnosed with diabetes (14.8%) when compared to Connecticut (9.3%) and the nation (9.8%). This is a concern for the community in terms of prevention, but even more concerning is that diabetics in Waterbury are less likely to manage their condition. Fewer diabetics are taking insulin, checking their blood glucose levels on a daily basis, seeing a health professional for their condition, having a health professional conduct an A1C test or foot check, and attending self-management courses. Specifically, only 33.1% of diabetic respondents have taken a course in how to manage their diabetes compared to 39.9% of diabetics across Connecticut and 52.2% of diabetics across the nation.



Household Telephone Survey Summary of Findings

A number of areas of opportunity were identified through the household telephone survey. The first area was access to care. Residents are more likely to have trouble affording out-of-pocket expenses despite having equitable health insurance coverage. They are also less likely to receive preventive screenings related to oral health and women's health. The second area was chronic health conditions. Respiratory conditions presented as an issue with a higher proportion of residents saying that they and their children have asthma. A contributing factor to asthma rates may be the proportion of residents who smoke cigarettes. Cardiovascular disease and diabetes

also presented as concerns among residents. Contributing factors to these conditions may be the proportion of residents who are overweight or obese and have high blood pressure. The third area was the mental health status of Waterbury. Residents have more days of poor mental health, are more likely to experience depression and be diagnosed with an anxiety disorder.

FOCUS GROUPS OVERVIEW

Background

A total of six focus groups were held at various locations throughout Waterbury in February 2013. Two of the groups were conducted with health care providers associated with the two hospitals; four groups were conducted with members of neighborhood associations. Focus group topics addressed access to care, cultural competency, physical activity, nutrition/healthy eating habits, weight/obesity, and health information. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through the CHNA partners. In exchange for their participation, health care providers were given a $25 gift card; community members received $25 cash. Two discussion guides developed in consultation with the Greater Waterbury Health Improvement Partnership, were used to prompt discussion and guide the facilitation.

In total, 57 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of providers and community members and may not necessarily represent all providers and residents of Waterbury.

The following section provides a summary of the focus group discussions including key themes and select comments.

Health Care Provider Focus Groups Key Findings

Access to Care

Access to care was an area of shared concern among Saint Mary's and Waterbury Hospital physicians. Physicians agreed that the greatest barriers to accessing care in Waterbury are an inadequate number of physicians, particularly primary care physicians, and health insurance-related issues. The primary care shortage in Waterbury has prohibited patients from having assured and timely access to care, even if they are insured. Many patients with medical homes are still using the ED due to the limited hours of clinics and the overwhelming demand for limited appointment slots. Participants also pointed out that primary care physicians are the lowest paid providers and care for the most challenging payer mix.

Participants shared that low Medicaid reimbursements limit the number of patients that primary and specialty physicians are willing to see. One physician stated, "It costs us more to see the

patients than what we receive in reimbursement." Additional barriers to accessing care included a lack of awareness of available services among eligible patients, limited bilingual services for non-English speaking residents, transportation, and co-payments. Another physician stated, "Even residents with health insurance are financially stressed and don't follow through on their care due to copayment costs."

There was general consensus among providers that patients with mental and/or behavioral health issues are underserved. It is difficult for these patients to receive the care that they need because providers are hesitant to "take responsibility for them" and services are limited. Providers are reluctant to be the "physician of record." Other underserved populations included the seasonally insured, service industry workers, and minority populations.

Participants listed a number of resources for uninsured and underinsured residents. The Waterbury Health Access Program (WHAP) was seen as particularly successful in linking needy patients with volunteer physicians and insurance. Lack of funding could jeopardize the future of the program.

Key Health Issues and Challenges

Mental and behavioral health issues were seen as key health issues in the community. One physician suggested that there was "widespread emotional despair" within the city. Other concerns were that elderly patients suffered from dementia, late-stage breast cancer diagnoses, and obesity.

Related to obesity, participants saw a number of challenges for residents trying to stay physically fit and eat a healthy diet. Fresh fruits are expensive and not widely available following recent closings of several supermarkets. An increase in farmers' markets was seen as a positive development. Other barriers included residents' awareness of healthy diets, as well as their willingness to dedicate resources to costly fruits and vegetables (over less expensive fast food alternatives). Compounding challenges to maintaining health, a lack of accessible, safe recreational areas was noted.

Participants provided several recommendations for improving the health of the community. Better patient navigation, extended clinic hours to serve residents instead of the ED, and higher reimbursement for Medicaid patients, were among recommendations provided. Participants agreed that mental health treatment options also needed to be expanded. Investments to improve poor economic conditions in the city needed to continue.

Provider Resources

Providers agreed that insurance-related issues are one of the top obstacles that they face in providing care. The amount of paperwork required by each plan burdens medical offices and takes away from direct patient care. Providers also stated that a merger between the two hospitals in Waterbury would create more seamless care and financial stability that would allow for more modern technology.

Local health departments were viewed as helping to meet the needs of the Waterbury community; however, most participants were not aware of specific activities. The general consensus was that more support from entities across the community was needed. One participant stated, "It comes down to shared responsibility. Everyone needs to take a part."

Community Resident Focus Groups Key Findings

Access to Care

A number of issues were identified by community residents as barring people from accessing health care. Many issues were centered on the cost of care. Participants identified lack of health insurance, the cost of copayments and medications, and increasing premiums and deductibles, specifically. They also expressed concern that Husky Care (Medicaid) was often not accepted by providers and that people were "looked down upon" for having it. Other issues included transportation, clinic hours of operation, language barriers, lack of awareness of services, and legal status. Participants stated that it can "take all day" to see the doctor due to the limited number of bus stops and long wait times between rides. They also stated that the only place to receive care after hours was the ED since clinics and private medical offices were closed. Hispanics/Latinos and Albanian residents were viewed as most impacted by language barriers.

Participants felt that a number of populations within the community were not being adequately served by local health services. These included African Americans, Hispanics/Latinos, single mothers with children, the homeless, mentally ill residents, seniors, and teens. Participants explained that for those seniors who need assistance with Activities of Daily Living (ADL), traveling to the Veteran's Administration Hospital in West Haven (45 minutes away) is a burden. They also expressed that teens are often not able to afford medication and are struggling with issues like sexually transmitted diseases. Resources identified that cared for underserved populations included hospital EDs, health clinics, Planned Parenthood, and the Malta House of Care van.

Dental care and mental health care were viewed as lacking services in the community. Participants agreed that dental care is largely unavailable without insurance. There was general consensus that there was "no place to go" for mental health care services. One person stated, "You have to commit a crime to get mental health care."

Key Health Issues and Challenges

More than 10 health issues were identified as major concerns in the community. Among the issues, mental and behavioral health issues were mentioned several times. In particular, participants noted wide-spread abuse of medicines like Nyquil and addictions to pain medication. Several factors were seen as contributing to addictive behavior including long delays in getting appointments and automatic refilling of pain medication prescriptions. Participants also noted tobacco use as a major concern. They observed that "Everyone smokes

cigarettes." An increased popularity of small cigars due to the lower cost compared to cigarettes was noted.

Participants noted a number of challenges for people in the community trying to stay physically fit and eat healthier. There was broad agreement that Waterbury does not offer adequate opportunity for physical activity. Comments included: "There are no safe parks." "Sidewalks are not in good condition." "Streets are of an old design; they are not wheelchair or stroller friendly." "There are no bike trails." "Today's parks have crooked slides and broken sprinklers." "There are syringes on the ground."

Programs that are available for recreation have a cost associated with them. Two organizations, the Police Athletic League (PAL) and the YMCA, were seen as positive entities, although both have fees for participation. Participants agreed that fresh fruits and vegetables were available year-round, but that barriers like cost, transportation, and location keep residents from accessing them widely. The farmer's market was seen as a step in the right direction; however, one participant said "You have to fight your way through panhandlers and the homeless to shop there." One solution was to increase the number of community gardens in Waterbury.

A number of weaknesses related to the socio-economic and physical environment of the community were identified. Participants stated that there was a lack of jobs in the area and that youth didn't have work opportunities. Poverty conditions often caused parents to "hop from apartment to apartment" to avoid paying rent, causing school transfers and disruption to children's education. Blight, littering, and poor school conditions were also concerns. One participant stated, "Residents are not invested in the areas where they live."

Community Aspirations & Capacity

Participants offered a number of suggestions for improving the health of the community. Specific examples included expanding access to care by "bringing back" the StayWell Health Center van; sponsoring free dental clinics; offering more health screenings and smoking cessation programs; and promoting on-going health education campaigns. Cleaning up the city park, improving the transportation system, sponsoring more community gardens, and providing safe and clean public restrooms in the downtown area were suggested to improve the city environment.

Participants urged community organizations to concentrate on the city as a whole and work to improve the socio-economic factors burdening residents. They also cited the need for more general counseling services and community mentors for the youth. Participants thought that efforts needed to be made to "instill more pride in the city" in an effort to encourage more community involvement and advocacy. Religious organizations were seen as untapped resource in these efforts.

Focus Group Summary of Findings

The focus group participants were grateful for the opportunity to share their thoughts and experiences; many expressed support for community-wide efforts to improve the health status of Waterbury. Identified community strengths included area healthcare providers, specifically the hospitals, health clinics, and local health departments. Areas of opportunity included expanding access to care for residents, availability of resources to improve physical activity and healthy eating, and concerns of blight and community investment.

KEY INFORMANT INTERVIEWS OVERVIEW

Background

An online survey was conducted among area "Key Informants." Key informants were defined as community stakeholders with expert knowledge including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders.

Holleran staff worked closely with the Greater Waterbury Health Improvement Partnership to identify key informant participants and to develop the Key Informant Survey Tool. Two-hundred and five (205) completed surveys were collected between February and April 2013. A listing of key informant participants can be found in Appendix D.

The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within Waterbury.

Key Informant Study Findings

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top health issues that they perceived as being the most significant. The issues that were most frequently selected were:

1. Mental/Behavioral Health
2. Overweight/Obesity
3. Access to Health Care/Uninsured/Underinsured
4. Substance Abuse/ Alcohol Abuse
5. Heart Disease

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top five issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top five. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant of their top five.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Mental/Behavioral Health	78%	32%
2	Overweight/Obesity	66%	14%
3	Access to Health Care/ Uninsured/Underinsured	63%	26%
4	Substance Abuse/Alcohol Abuse	61%	7%
5	Heart Disease	42%	5%
6	Diabetes	41%	2%
7	Cancer	34%	7%
8	Caregiver Needs	30%	4%
9	Dental Health	21%	0%
10	Tobacco	20%	1%
11	Maternal/Infant Health	16%	1%
12	Stroke	11%	1%
13	Sexually Transmitted Diseases	7%	0%
14	HIV/AIDS	6%	1%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top five.

"What are the top 5 health issues you see in your community?"

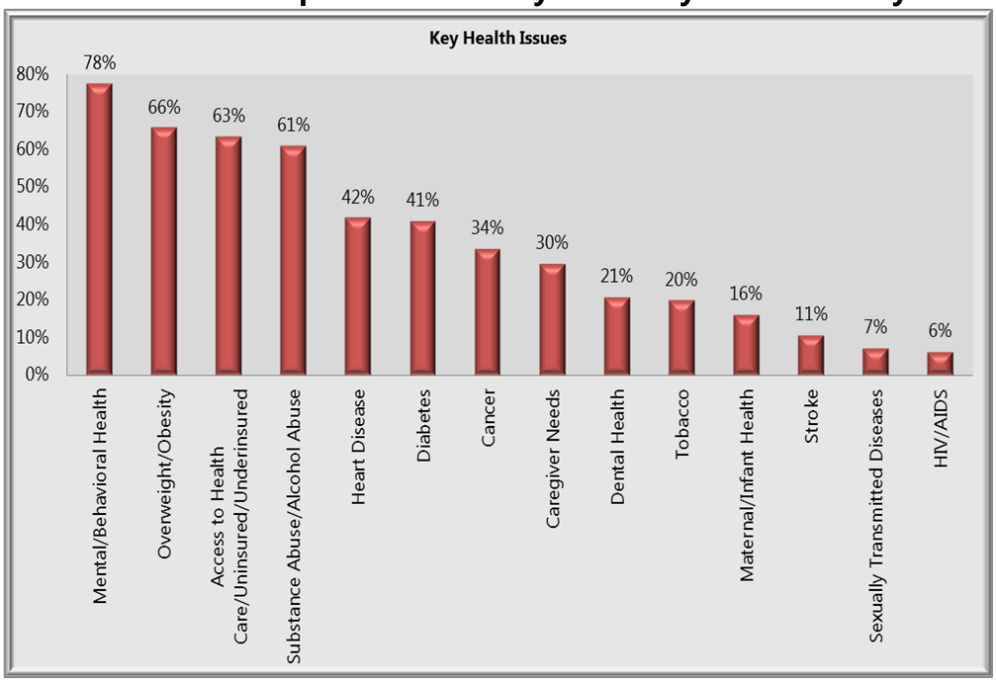


Figure 1: Ranking of key health issues

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in Table 2.

Health care access appears to be a significant issue in the community. As illustrated in Table 2, none of the informants strongly agree to any of the health care access factors. Most respondents 'Disagree', with community residents' ability to access care. Availability of mental/ behavioral health providers garnered the lowest mean responses (2.06), compared to the other factors.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access."

Table 2: Mean Responses for Health Care Access Factors

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.19	Neither agree nor disagree
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.90	Disagree
Residents in the area are able to access a dentist when needed.	2.93	Disagree
There are a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.33	Disagree
There are a sufficient number of bilingual providers in the area.	2.40	Disagree
There are a sufficient number of mental/ behavioral health providers in the area.	2.06	Disagree
Transportation for medical appointments is available to residents in the area when needed.	2.53	Disagree

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Inability to Pay Out-of-Pocket Expenses (co-pays, prescriptions, etc.)
- Lack of Health Insurance Coverage
- Inability to Navigate Health Care System

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. The third column in the table depicts the percentage of respondents that rated the barrier as being the most significant facing the community.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue	Percent of respondents who marked it as the most significant barrier
1	Inability to Pay Out of Pocket Expenses	151	80%	19%
2	Lack of Health Insurance Coverage	135	71%	20%
3	Inability to Navigate Health Care System	131	69%	26%
4	Lack of Transportation	107	57%	4%
5	Language/Cultural Barriers	86	46%	1%
6	Basic Needs Not Met (Food/Shelter)	80	42%	8%
7	Time Limitations	82	43%	3%
8	Availability of Providers/Appointments	80	42%	14%
9	Lack of Child Care	45	24%	1%
10	Lack of Trust	42	22%	2%

Figure 2 shows a graphical depiction of the frequency of selected barriers to health care access.

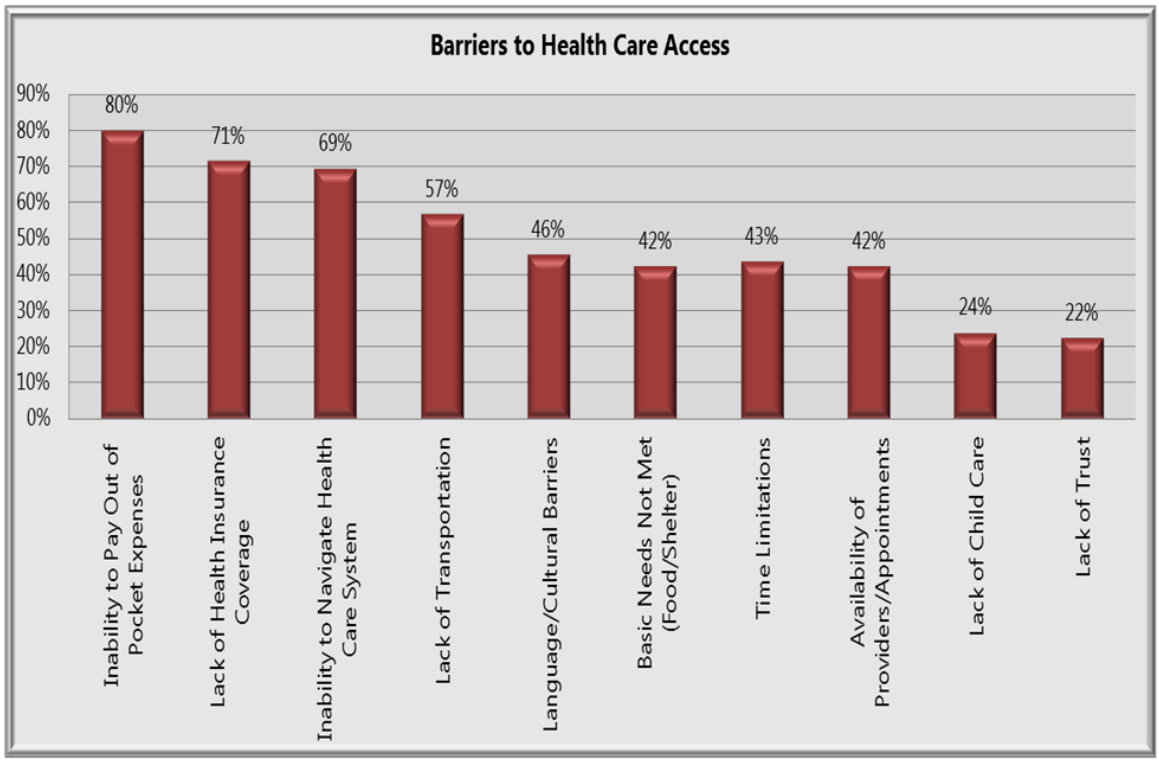


Figure 2: Ranking of barriers to health care access

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 3, the majority of respondents (82%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

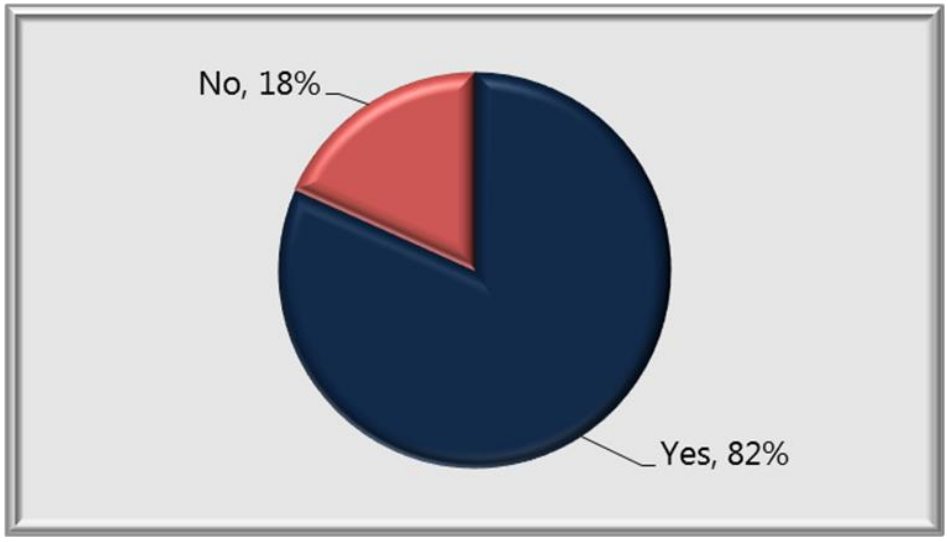


Figure 3: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Uninsured/underinsured and low-income/poor individuals were considered underserved populations along with homeless individuals and seniors/aging/elderly individuals. In addition, several respondents felt that racial/ethnic minorities and immigrant/refugee population were underserved.

Table 4: Underserved Populations

	Underserved population	Number of respondents selecting the population
1	Uninsured/Underinsured	98
2	Low-income/Poor	82
3	Homeless	64
4	Seniors/Aging/Elderly	41
5	Hispanic/Latino	35
6	Immigrant/Refugee	33
7	Black/African-American	31
8	Children/Youth	29
9	Disabled	28
10	Young Adults	22
11	Lower Middle Class	3
12	Mental Health/Addicts	1
13	Veterans	1
14	LGBT	1

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. As shown in Figure 4, the majority of respondents (81%) indicated that uninsured and underinsured individuals go to the Hospital Emergency Department for medical care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

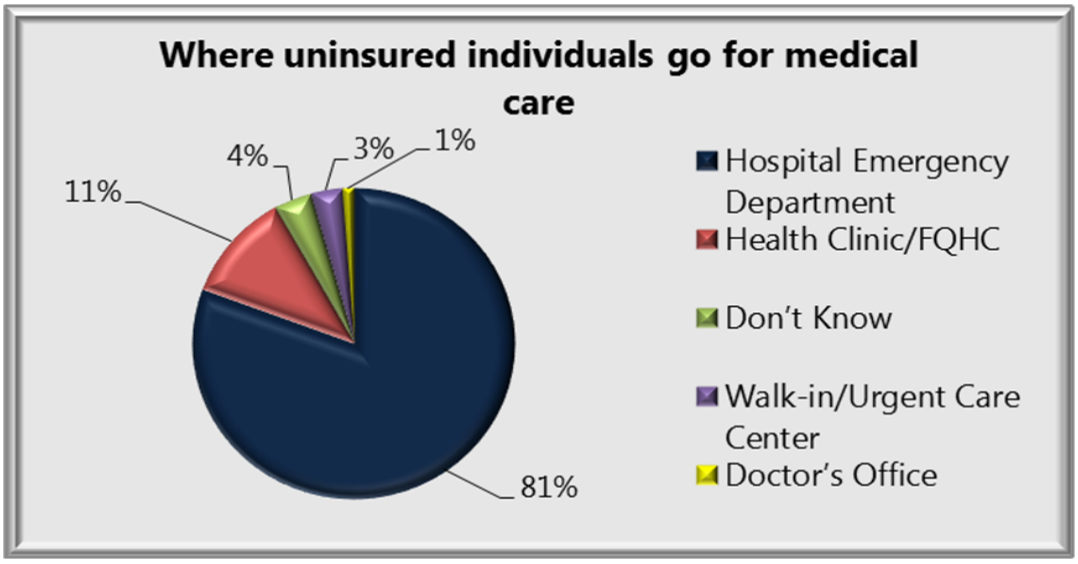


Figure 4: Key informant opinions of where uninsured individuals receive medical care

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that free and low cost medical and dental care, and mental health services are needed. In addition, informants want to see more health education and outreach and more transportation/assisted transportation. Table 5 includes a listing of the resources mentioned ranked in order of the number of mentions.

Table 5: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Free/Low Cost Dental Care	111
2	Mental Health Services	108
3	Free/Low Cost Medical Care	93
4	Health Education/Information/Outreach	78
5	Transportation/Assisted Transportation	69
6	Health Screenings	63
7	Bilingual Services	58
8	Prescription Assistance	58
9	Substance Abuse Services	52
10	Primary Care Providers	39
11	Medical Specialists	32
12	Free/Low Cost Dental Care	111

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Education/Knowledge
- Chronic Conditions/Diseases
- Cultural Norms
- Environment/Safety

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Collaboration/Coordination
- Improved Access to Medical Care, Dental Care, and Mental Health Services
- Improved Access to Affordable Exercise and Nutrition Programs
- Need For Patient Navigation
- Enhanced Programs/Outreach for Youth and Seniors
- Enhanced Community Space

Key Informant Interviews Summary of Findings

Key informants acknowledged that mental/behavioral health, overweight/obesity, and access to care are the most significant health issues in the community. Related to access to care, informants agreed that residents do not have sufficient access to providers and experience a number of barriers in seeking care. In particular, they felt that residents are not able to see specialists, dentists, and mental/behavioral health providers when they need to. They also felt that there are not enough bilingual providers and providers accepting Medicaid and medical assistance. Additional barriers for residents seeking care are out-of-pocket expenses, lack of health insurance coverage, and the inability to navigate the health care system. Informants recommended a number of resources to improve access to care. Among these, free/low cost dental care, mental health services, and free/low cost medical care were cited the most.

Eighty-two percent of informants agreed that there are underserved populations living in Waterbury. Of these populations, they felt that the uninsured/underinsured, low-income/poor, and homeless are the most underserved. When seeking medical care, these populations were thought to most often utilize hospital emergency departments and federally qualified health centers/clinics.

The last portion of the survey asked key informants to identify challenges in the community in maintaining healthy lifestyles and to make recommendations or suggestions for improving health and quality of life. In addition to issues related to access to care, informants listed motivation/effort, education/knowledge, cultural norms, and environment/safety as challenges in the community. To address these issues, informants recommended increasing awareness, education, community outreach, and community collaboration and coordination. They also suggested that more programs for youth and seniors be offered and that the community space be enhanced.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS & PLANNING

Prioritization Session

On June 17, 2013, approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix G.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans. Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

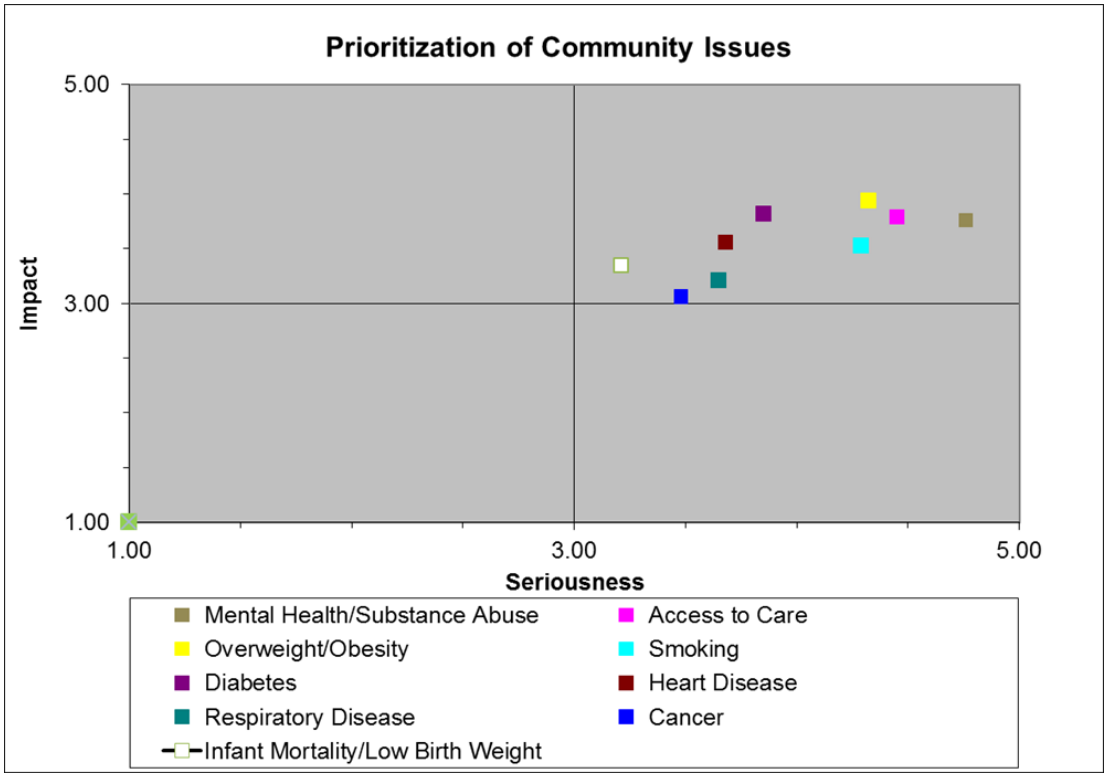
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Goal Setting

Following the prioritization session, The Greater Waterbury Health Improvement Partnership representatives met to review the identified priorities and develop goal statements to guide community-wide health improvement efforts. The following goals were adopted for each priority area:

Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Overweight and Obesity

Goal: Promote health and reduce chronic disease through healthful eating and physical activity.

Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Action Planning

To set a course for ongoing community health improvement activities and evaluation, a Community Health Improvement Plan (CHIP) was developed by the Greater Waterbury Health Partnership. Additionally, in line with requirements set forth in the ACA, specific Implementation Strategies, outlining how each hospital would work to address the identified needs, were created.

The CHIP and Hospital Implementation Strategies were adopted in September 2013. These documents, as well as a report of the CHNA are available on the partner websites.

APPENDIX A: Secondary Data Profile References

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APPENDIX B: Household Telephone Study Statistical Considerations

The Household Telephone Study sampling strategy was designed to represent Waterbury and its surrounding towns. The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (1,121) yields an overall error rate of +/-2.9% at a 95% confidence level. This means that if one were to survey all residents of Waterbury, the final results of that analysis would be within +/-2.9% of what is displayed in the current data set.

Data collected from the 1,121 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for Connecticut and the United States are included when available to indicate how the health status of Waterbury residents compares on a state and national level. All comparisons represent 2011 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to Connecticut and/or national data because of survey modifications.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area. The data was statistically weighted to correct for this over-representation of females. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: Household Telephone Study Participant Demographics

Gender and Age

Demographic Category		Waterbury CT 2013 BRFSS (n = 743)	Surrounding Towns 2013 BRFSS (n = 378)
Gender	Male	36.7%	35.4%
	Female	63.3%	64.6%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 735)**	**Surrounding Towns 2013 BRFSS (n = 374)**
Age Group	18 - 24	2.9%	4.8%
	25 - 34	9.0%	5.3%
	35 - 44	10.2%	12.8%
	45 - 54	17.0%	22.7%
	55 - 64	24.4%	21.7%
	65 years and over	36.6%	32.6%

Race and Ethnicity

Demographic Category		Waterbury CT 2013 BRFSS (n = 737)	Surrounding Towns 2013 BRFSS (n = 378)
Hispanic/Latino	Yes	13.0%	2.6%
	No	87.0%	97.4%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 715)**	**Surrounding Towns 2013 BRFSS (n = 377)**
Race	White	73.6%	94.4%
	Black or African American	16.5%	0.8%
	Asian	1.8%	1.6%
	Native Hawaiian or Other Pacific Islander	0.4%	0.0%
	American Indian or Alaska Native	1.4%	0.5%
	Other	6.3%	2.7%

Marital Status and Children

Demographic Category		Waterbury CT 2013 BRFSS (n = 734)	Surrounding Towns 2013 BRFSS (n = 376)
Marital Status	Married	36.2%	58.0%
	Divorced	16.9%	13.0%
	Widowed	17.8%	13.8%
	Separated	3.0%	0.8%
	Never Married	22.9%	12.5%
	Member of an unmarried household	3.1%	1.9%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 742)**	**Surrounding Towns 2013 BRFSS (n = 378)**
Number of Children in Household	None	74.5%	70.9%
	One	12.3%	14.3%
	Two	8.1%	12.2%
	Three	3.2%	2.4%
	Four	1.1%	0.0%
	Five	0.7%	0.3%
	Six	0.1%	0.0%

Educational Attainment

Demographic Category		Waterbury CT 2013 BRFSS (n = 739)	Surrounding Towns 2013 BRFSS (n = 376)
Education Level	Never attended school or only attended kindergarten	0.4%	0.5%
	Grades 1 through 8	3.7%	2.1%
	Grades 9 through 11	6.5%	2.1%
	Grade 12 or GED	31.9%	20.7%
	College 1 year to 3 years	31.8%	27.1%
	College 4 years or more	25.7%	47.3%

Employment Status

Demographic Category		Waterbury CT 2013 BRFSS (n = 741)	Surrounding Towns 2013 BRFSS (n = 376)
Employment Status	Employed for wages,	38.9%	49.2%
	Self-employed,	3.6%	10.1%
	Out of work for more than 1 year,	4.3%	2.7%
	Out of work for less than 1 year,	2.8%	1.6%
	Homemaker,	3.5%	3.2%
	Student,	1.3%	1.9%
	Retired, or	34.5%	26.9%
	Unable to work	10.9%	4.5%

Income

Demographic Category		Waterbury CT 2013 BRFSS (n = 574)	Surrounding Towns 2013 BRFSS (n = 301)
Income	Under $10,000	8.4%	2.0%
	$10,000 to less than $15,000	13.2%	5.3%
	$15,000 to less than $20,000	6.6%	2.3%
	$20,000 to less than $25,000	10.8%	4.3%
	$25,000 to less than 35,000	14.5%	8.3%
	$35,000 to less than 50,000	14.1%	12.6%
	$50,000 to less than 75,000	14.6%	17.9%
	$75,000 or more	17.8%	47.2%

APPENDIX D: Key Informant Participants

Name	Title	Organization
Tina Agati	Executive Director	Literacy Volunteers of Greater Waterbury
Eric Albert	President	Albert Brothers, Inc.
Michele A. Albini	Constituent Service Aide	City of Waterbury
Janine Altamirano	Program Coordinator	Waterbury Department of Public Health
Maryangela Amendola	Director	Chase Family Resource Center
Joel Becker	President & Chief Executive Officer	Torrco
Carolann Belforti	JobLinks Coordinator	Northwest Regional Workforce Investment Board
Michelle Bettigole	Executive Director	The Watermark at East Hill
Christine Bianchi, MSW, LCSW	Chief Developmental Officer	Staywell Health Care, Inc.
O. Joseph Bizzozero, MD	Administration	Alliance Medical Group
Charles Boulier	President & Chief Executive Officer	Naugatuck Savings Bank
Samuel Bowens	HIV Prevention Coordinator	Waterbury Health Department
Betty Bozzuto	Chief Nursing Officer	Saint Mary's Hospital
Ellen Brotherton	Assistant Director	Western CT Mental Health Network - Waterbury
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Katherine Carten	Parish Administrator	Saint Michael's Parish, Naugatuck
Ellen Carter	Program Officer	Connecticut Community Foundation
Kathy Case	Director of Program Management	Waterbury ARC
Julie Clark	Wellness Environmental Lifestyle Consultant	
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Meghan Cleary	Director of Nursing	Wolcott View Manor
Mary Conklin	Housing Attorney	Connecticut Legal Services
Joseph G. Conrad	Program Director	Connecticut Counseling Centers, Inc.
Ronald Conti	Vice President	Heritage Village
Marilyn Cormack	President	BHCare
JoAnne Cosgriff, MD	Director, Performance Improvement	Waterbury Hospital
Janice Crelan	Assistant Treasurer	Hubbard-Hall, Inc.
Kelly Cronin	Executive Director	Waterbury Youth Services
Andrea Cuff, APRN		Chase Outpatient
Jerome Dais	Elder	Family Worship Center
Kristen Davila	Director	Morris Senior Center
Nancy Deming	Director	VNA Northwest
Catherine R. Dinsmore	Senior Center Director	Falls Avenue Senior Center
Deborah Duarte	Missions President	Community Tabernacle Outreach Center
Richard Dumont	Community Resident	
Kris Durante	Coordinator	Bridge To Success
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Tim Epperson	Food Pantry Coordinator	Greater Waterbury Interfaith Ministries
Michelle Fica	Managing Attorney	Connecticut Legal Services
Bethany Ann Fickes	Office Assistant	Saint Mary's Hospital
Christina Fishbein	Executive Director	Western Connecticut Area Agency on Aging
Ron Flormann	Chief Commercial Officer	Glenwood Systems, LLC
Natalie Forbes	Grant Coordinator	Waterbury Hospital
Auguste Fortin, VI, MD	Physician	Yale Primary Care Residency Program/ Waterbury Hospital
Yvette Highsmith Francis	Regional Director	Community Health Center, Inc.
Todd Gaertner	Nursing Home Administrator	Lutheran Home of Southbury

Sarah Geary	Constituent Services Manager	City of Waterbury
Sharon Gesek	Director of Elderly Services	Town of Southbury
Bill Gibbs	Owner	Bill Gibbs Massage Therapy
Mary-Kate Gill	Director of Elder Services	New Opportunities, Inc.
Jackie Giordano, RN	Nurse	Saint Mary's Hospital
Michelle Godin	Director	Saint Mary's Hospital
Joe Gorman	Supervisor of Health & Physical Education	Waterbury Board of Education
Lydia Granitto	Membership & Marketing Manager	Girl Scouts of Connecticut
Bernadette Graziosa	President	The Grotto Restaurant & Mrs. G's Gift Baskets
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Joy Hall	Director	Salvation Army
Lori Hart	Director	Bridge To Success
Robyn Hawley	Director of Behavioral Health	Catholic Charities Archdiocese of Hartford
Eileen Healy	Executive Director	Independence Northwest, Inc.
Tina Herman	Assistant Director of Critical Care	Waterbury Hospital
Arlene G. Herrick	Property Manager	Grace Meadows Elderly Housing
Chris Hibbs	Health & Wellness Director	Greater Waterbury YMCA
Stephen Holt	Assistant Professor	Yale Primary Care Residency
Geralyn Hoyt	Chief	Southbury Ambulance
Lucia Hughes	Manager	Waterbury Hospital
Stephen Huot, MD	Director	Yale Primary Care Residency Program/ Waterbury Hospital
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Eric Hyson, MD	Attending Physician	Waterbury Hospital
Sandi Iadarola	Chief Nursing Officer	Waterbury Hospital
Azhar Imam, MD	Chief of Psychiatry	Saint Mary's Hospital
Kristen Jacoby, MPH	President/Chief Professional Officer	United Way of Greater Waterbury
Donna Johnson	Community Relations Liaison	Diagnostic Radiology Associates
Mark Johnson, LMFT	Program Director	Wellspring Foundation
Jan Kennedy	Executive Director	Cardiology Associates of Greater Waterbury, LLC
Elizabeth Korn, APRN	Nurse	Saint Mary's Hospital
Lisa Labonte	SNS Director	New Opportunities, Inc.
Leo Lavallee	Principal	Waterbury Arts Magnet School
Stephen Lewis	Chief Executive Officer/President	Thomaston Savings Bank
The Rev. Jeanne Lloyd	Minister	Mattatuck Unitarian Universalist Society
Ben Loveland	Assistant Director	Waterbury Hospital
Vanessa Lucewicz	Practice Manager	Franklin Medical Group
Frederick Luedke	Chairman, Board of Greater Waterbury Health Network Inc.	Waterbury Hospital
Neal Lustig	Director of Health	Pomperaug Health District
Robin Marino	Clinical Manager	Saint Mary's Hospital
Judith Martin	Program Coordinator	Child & Adolescent Behavioral Health
Kate Mattias	Executive Director	National Alliance on Mental Illness Connecticut
Bahar Matusik	Clinical Pharmacy Manager	Waterbury Hospital
Jennifer McGarry	Patient Services Manager	Leukemia and Lymphoma Society
Patricia A. McKinley	Strategic Volunteer to Non-Profit Organizations	Waterbury Health Home Coalition; United Way Greater Waterbury; Connecticut Community Foundation
Kathleen McManamy, LCSW	Regional Supervisor	Connecticut Community Care, Inc.
Kathleen McNamara	Community Resident	
Emmett McSweeney	Library Director	Silas Bronson Library
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Chris Miller	Administrative Fellow	Saint Mary's Hospital

Thomas Missett	Chief Development Officer	Waterbury Hospital
Alan C. Mogridge	Executive Director	Valley YMCA
Peg Molina	Director of Social Services	Town of New Milford
Patrick Morgan	Interim Director Surgical Services	Waterbury Hospital
Drew Morten	Physician Assistant	Connecticut Academy of Physician Assistants
Luci Moschella	Nursing Supervisor	Waterbury Health Department
Lois Mulhern	Nursing Supervisor	Waterbury Health Department
Melanie Nachajska, LCSW		YNA Health Care
James O'Rourke	CEO	Waterbury YMCA
Peggy Panagrossi	Executive Director	Safe Haven of Greater Waterbury
Kim Pernerewski	President	National Alliance on Mental Illness Waterbury
Peter Porrello, MD	Physician	Waterbury Hospital
Pamela Pratt	Manager, OP Behavioral Health	Saint Mary's Hospital
Fenn Quigley	Community Resident	
Ernst Racine, Jr.	Family Center Coordinator/Fatherhood Specialist	Catholic Charities
Loryn Ray, MPH	Director of Elderly Services	Town of Woodbury
Pamela Redmond	Public Affairs Officer	VA Connecticut Healthcare System
Thomas E. Reinahrdt, MD	Chief of Psychiatry	Waterbury Hospital
Laurie Reisman	Director of Operations	Family Services of Greater Waterbury, Inc.
JoAnn Reynolds-Balanda	VP Community Impact	Untied Way of Greater Waterbury
Diane Rokosky, R.N		Public Health Deptartment
P. Russell	Community Resident	
William Rybczyk	Director Research, Development, & Planning	New Opportunities, Inc
Linda Sapio-Longo, APRN	Family Nurse Practitioner	Waterbury Hospital Infectious Disease Clinic
John A. Sarlo	Director	Mattatuck Senior Center, Inc.
Donita Semple	Senior Manager, Performance Improvement	Waterbury Hospital
Loraine Shea	Director	Waterbury Hospital
Frank Sherer	Senior Vice President	Timex Group
Carl Sherter, MD	Chief of Staff	Waterbury Hospital
Catherine Sousa	Supervisor of Patient Transport	Saint Mary's Hospital
Linda Spadaccini	Library Director	Waterbury Hospital
Susan Stauffacher	Chairman	Roxbury Council on Aging
Gary Steck	Chief Executive Officer	Wellmore Behavioral Health
Monica Stokes	Assistant Manager Customer Support	Waterbury Hospital
Christine Thomas-Melly	Benefits Manager	Waterbury Hospital
Donald Thompson	Chief Executive Officer	Staywell Health Center
Joseph M. Tuggle, MD	Physician	Complete Newborn Care, PC
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Kara Vendetti	WIC Program Coordinator	Waterbury Health Department-WIC Program
Deborah Vitarelli	Executive Director	Waterbury Arc, Inc.
Kathy Volz	Practice Manager CFHC	Franklin Medical Group at Saint Mary's Hospital
Chad Wable	President & Chief Executive Officer	Saint Mary's Hospital
Julie Weidemier	Assistant Director	Waterbury Hospital
Claude E. Williams	Executive Director	Mount Olive A.M.E. Zion Senior Citizens Center, Inc.
Jeffrey Williams	Grant Writer	Waterbury Hospital
Eileen Woods	Assistant Director Telemetry	Waterbury Hospital
Kathy Woods	Executive Director	Living in Safe Alternatives, Inc.
D. Woolley	VP Human Resources	Waterbury Hospital
Randy York	Infant Immunization Coordinator	Waterbury Health Department
Mary Zasada	Clinical Informatics Manager	Saint Mary's Hospital
Melissa Zwang	Program Director	New Opportunities, Inc.
Patricia Zuccarelli	Director	Department of Children & Families

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

Waterbury Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Waterbury Hospital was the first hospital in the city of Waterbury and has served the area since 1890. In its first year, Waterbury Hospital served 85 patients and had a staff of 21. It is now licensed for 357 beds and employs more than 2,000 people. The hospital serves approximately 15,000 inpatients, 160,000 outpatients, and 58,000 emergency department visits annually. The mission of Waterbury Hospital is to provide compassionate high quality health care services through a family of professionals and services. The vision of Waterbury Hospital is to be the health care organization of choice by providing superior customer service to patients and physicians.

Waterbury Hospital primarily serves the city of Waterbury and its' surrounding towns. In 2013, Waterbury Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with the Greater Waterbury Health Improvement Partnership. The partnership consists of Waterbury Hospital, Saint Mary's Hospital, Waterbury Department of Public Health, City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Waterbury Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Waterbury Hospital's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs. Waterbury Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA.

THE CHNA PROCESS

A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Identified Community Needs

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Connecticut Department of Public Health, and Centers for Disease Control and Prevention. The information profiles the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Waterbury Hospital in addressing the identified barriers.

Key Informant Interviews were collected via an online survey administered by Holleran. A total of 205 community leaders, including public health experts, health and human services providers, and representatives of underserved populations participated in the survey. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 CHNA and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated and facilitated by the Greater Waterbury Health Improvement Partnership. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives for the day were outlined as follows:

- To review recently compiled community health data and highlight key research findings;
- To initiate discussions around additional key health issues not represented in the CHNA;
- To prioritize the community health needs based on select criteria

Prioritization Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.
Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans.

Master list of community priorities (Presented in alphabetical order.):

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

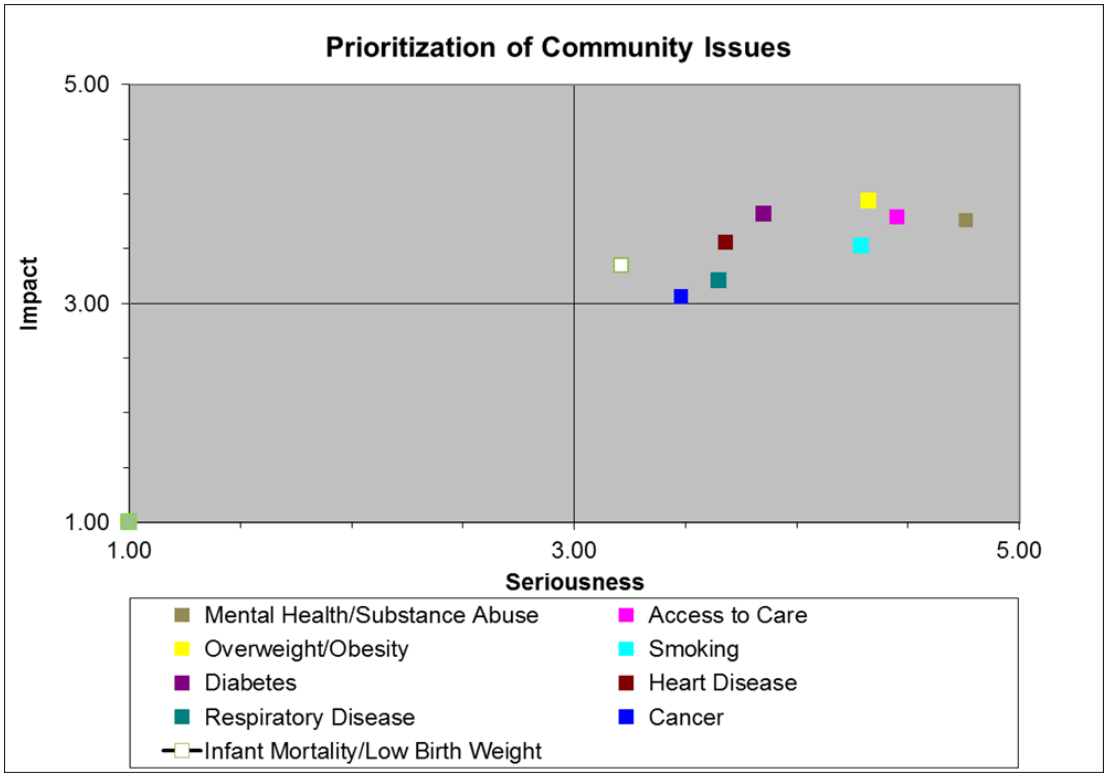
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following five priority areas for Waterbury were adopted:

A. Access to Care
B. Mental Health/Substance Abuse
C. Overweight/Obesity
D. Smoking

WATERBURY HOSPITAL'S STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Waterbury Hospital's Implementation Strategy illustrates the hospital's specific programs and resources that will support ongoing efforts to address the identified community health priorities. This work will be supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, related objectives and strategies, and inventory of existing community assets and resources for each of the four priority areas are listed below.

A. ACCESS TO CARE

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of persons with health insurance
- Increase the proportion of persons who have a specific source of ongoing care
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
- Increase the number of health providers that accept Medicaid and Medicare

Strategies:

1. Increase the number of patients screened and enrolled in insurance programs by WHAP case managers by 10% at the 6 sites in the City of Waterbury by utilizing Certified Assisters to access the CT Health Exchange in response to the Affordable Care Act.

2. Increase the number of patients enrolled in Project Access by 10% for donated, primary and specialty care, reduced prescriptions and Medicare copay assistance, and donated lab and radiology hospital-based services.

3. Provide technical assistance to WHAP sites at St. Mary's Hospital and StayWell Health Center to enable them to track recidivism in the ED for non-emergency codes.

4. Offer 2 onsite bi-lingual medical Spanish classes for 15 clinical staff per class to improve communication with patients.

5. Introduce the CultureVision database to enable healthcare professionals and facilities to provide culturally competent patient care.

Existing Resources:

Underserved Populations
Waterbury Hospital works closely with local healthcare providers and community-based organizations to identify healthcare needs for underserved patients throughout the Waterbury community. Through these collaborations, Waterbury Hospital works to develop key programming for the city's vulnerable populations such as: the Waterbury Hospital Infectious Disease Clinic, which provides comprehensive HIV care to ~500 People Living with HIV/AIDS; and The Waterbury Health Access Program, which provides comprehensive case management services to over 3,000 uninsured and underinsured patients annually; and the Waterbury Hospital Chase Diabetes Disease Management Clinic, is one of the many free clinics offered at Chase Outpatient Center; others include Rheumatology, Surgery, Gastroenterology, Dermatology, Podiatry, and Psychiatry.

During 2012, Waterbury Hospital's spectrum of services continued to have a positive impact on the welfare of Waterbury's citizens. To remain consistent with Waterbury Hospital's mission, many of our services are targeted for vulnerable members of our community, including those who are uninsured or underinsured. In order to provide access to continuing high quality professional health care in the Greater Waterbury area, Waterbury Hospital is a site for 40 clinical programs for new health professionals including: Primary Care Residents, Surgical Residents, Nurses, Physician Assistants, Pharmacy Residents, and Radiology Techs. In addition the Waterbury Hospital Youth Pipeline Initiatives target the emerging workforce in area elementary, middle and high schools.

Health Professions Education

Yale Primary Care Internal Medicine Residency Program
During 2012, our Yale Primary Care Internal Medicine Resident activities included:

- Participation in research days at Yale and Waterbury/St. Mary's Hospitals;
- ACP regional and national meetings;
- The annual Health Fair held at the Waterbury YMCA;
- Home/office visits for clinic patients; and
- Educational seminars held at Waterbury Hospital and Yale University.

At Waterbury Hospital, we seek to train physicians who desire a generalist background to their careers in medicine. This program is unique in that it provides the medical residents the opportunity to work each year in a tertiary medical center at Yale-New Haven Hospital, a community hospital at Waterbury Hospital, and outpatient practice sites that include private practice offices and community health centers is unique in residency training. Our graduates are

highly sought after by private practice offices, hospitalist programs, and fellowship programs throughout the country.

Student Nurse Intern Program (SNI)
The SNI program is available for nursing students entering their senior year. The program provides these student nurses with shadowing opportunities so they can apply their content knowledge to authentic patient care situations. Staff RNs serve as the students' mentors as the students accompany them on their medical rounds. The goals of the program are: (1) to provide the student nurses with the knowledge and skills necessary to pass the NCLEX exam and (2) to socialize the student nurse in an attempt to decrease the stress of assimilating into the hospital's work environment, should they be hired as Graduate Nurses at Waterbury Hospital.

Physician's Assistant (PA) Students
P.A. students from Quinnipiac University completed clinical rounds in several departments around the hospital, including the Operating Room, Emergency Department, Behavioral Health, and Radiology. The experience is designed for the student to learn to apply the knowledge gained from didactic course work in medicine, surgery, and the basic and behavioral sciences into the clinical arena resulting in the ability to successfully manage patients in a thorough and comprehensive manner. The primary goal of clinical rotations is to expose the student to patients of all ages, patients in a variety of different settings, and patients with a broad range of medical, surgical, and psychosocial problems.

The P.A. students participate in:

- History taking;
- Examining the patient;
- Assisting in and/or performing diagnostic testing;
- Assisting in and/or performing therapeutic tasks;
- Oral presentations;
- Medical documentation of the patient encounter;
- Formulating a differential diagnosis and problem list;
- Formulating a treatment plan; and
- Counseling of patients regarding medication, diet, and lifestyle changes such as smoking cessation, exercise, and well-being.

Radiology Students from NVCC
The Naugatuck Valley Community College (NVCC) Radiology students are involved with many activities while assigned to Waterbury Hospital. Under the supervision of a NVCC clinical instructor and hospital radiologic technologists, the students are assigned to the various radiographic suites and modalities. During their assignment, students are performing or assisting with radiographic procedures, including chest x-rays, skeletal exams, fluoroscopic procedures, mobile x-rays in the various patient units, and surgical cases. The students also increase the number of individuals available in the department to assist in moving and transporting patients as well as chaperoning sensitive exams. In addition to the diagnostic

radiology the students are assigned to experiences in Interventional Radiology, CT, MRI, Nuclear Medicine, and Ultrasound. Students work in these modalities under the direct supervision of the hospital staff.

Waterbury Hospital's affiliation with NVCC as a clinical site for students has many benefits. Perhaps the single most important benefit is the hospital has a continuous stream of potential radiology employees. Students are in the program for 22 months and in that time become very familiar with the hospital equipment, routines, personal, and mission. This provides Waterbury Hospital with new employees who have a strong skill set and proven dedication to the hospital community.

Waterbury Hospital Youth Pipeline Initiatives

The Waterbury Hospital Youth Pipeline Initiatives were established in 2001 as a partnership between Waterbury Hospital and Waterbury Public Schools. The mission of the program is: "to close the achievement gap for minority and economically disadvantaged students in Waterbury so they can matriculate and compete nationally for placement in post-secondary education programs in preparation for health careers". Waterbury Hospital is committed to enhancing and enriching the academic opportunities and personal journeys of our youth, who are the emerging workforce of tomorrow. To this end, during 2012, Waterbury Hospital continued to provide 383 students and parents in Greater Waterbury with unique educational programs that will enhance the overall welfare of our community. The WH Youth Pipeline Initiatives had four focus areas during FY 2012, including:

Providing Early Acquaintance with Careers in Healthcare (PEACH)

Since its inception in 2004, Waterbury Hospital's Providing Early Acquaintance with Careers in Healthcare (PEACH) Program has engaged administrators, teachers, and students at Waterbury's North End Middle School and West Side Middle School to address projected shortages of healthcare workers and to close the achievement gap for students in Waterbury Public Schools. Through the PEACH Program, students engage with healthcare workers in a non-emergency setting and are informed of the variety of healthcare career opportunities available in our community. Each spring, approximately 100 seventh graders from Waterbury take part in a day-long PEACH tour at Waterbury Hospital, during which they visit at least six hospital departments and complete hands-on learning activities with hospital staff. Annually, Waterbury Hospital also offers its PEACH Spring Break Exploration Camp, this year 38 middle school students from Waterbury took part in: shadowing and hands-on learning activities at the hospital; CPR certification; and educational sessions at Bridgeport's Discovery Museum.

Parent Leadership Training Institute (PLTI)

In 2012, twenty four individuals from Greater Waterbury successfully completed Waterbury's PLTI, a 20-week curriculum teaching leadership and advocacy skills. Waterbury Hospital has hosted the Waterbury PLTI since 2000, and the program has trained and graduated over 175 area parents. PLTI's core mission is to impart leadership and advocacy skills to parents while simultaneously educating them about volunteerism, civic life, and the process by which state

and local governments enact and change laws. Each participant completes and implements a community project; examples of projects from 2012 include: a "High School Driving Education" program (a City-wide initiative to introduce safe driving techniques in high schools) and "The C.H.I.P. Forum" (Children Having Involved Parents—a series of workshops to underline the importance of giving encouragement and support to our children so they can succeed in life).

Parents Supporting Educational Excellence (PSEE)

In 2012, twenty-one individuals from Greater Waterbury successfully completed Waterbury's PSEE, a 13-week curriculum co-created by the Connecticut Center for School Change and the Connecticut Commission on Children for parents (defined broadly as parents, guardians, family members and grandparents) to instill leadership skills in education and to facilitate partnerships between school staff and parents to improve student learning.

WH Summer Bridge Program

During the summer of 2012, twenty-eight students from Waterbury, grades 6-11, participated in the WH Summer Bridge Program. 100% of meals were secured for the program from City of Waterbury Summer Food Program and 8 local restaurants/businesses. Students completed the following modules:

- 78.5 hours of Academic preparation
- 15 hours of job shadowing sessions (Radiology, Nuclear Medicine, Nursing, MRI, Case Management, Dr. S. Aronin (ID Inpatient Rounding), ICU Medical Rounds, Health Information Management, Access Rehab, Behavioral Health, Respiratory Therapy, Finance, WH ID Clinic, Security, Orthopedics, Pharmacy, Infection Control and Surgery.
- 14 hours of Photography instruction
- 4 hours of computer sessions
- 2 full-day field trips completed: one to Yale University for an admissions info session and campus tour and one to Hammonasset State Park including three educational sessions at Meigs Point Nature Center
- 3 hours of healthcare career searches
- 3 hours of college admissions presentations completed by UCONN Waterbury & Yale ROTC
- 1 hour of individual academic advising
- 2 hours of team building activities
- 2 hours of health topics presentations completed, including HIV 101 and Healthcare Jeopardy.

Waterbury Health Access Program

Waterbury Hospital is aware of the economic needs many patients in our community, and, as a result, we remain committed to the Waterbury Health Access Program. Founded in 2003 as a partnership between Waterbury Hospital, St. Mary's Hospital, StayWell Health Center (FQHC), and the Waterbury Health Department, the Waterbury Health Access Program improves access to high-quality medical care by providing comprehensive case management, pharmacy

assistance, and access to primary and sub-specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. During FY 2012, the Waterbury Health Access Program had over 4,700 active clients. Additionally, Waterbury Hospital provided $784,879 worth of donated services to WHAP's patients.

Waterbury Hospital Infectious Disease Clinic (WHIC)
The WHIC offers a comprehensive "one-stop shopping" model that provides patients with on-site primary and specialty services, medical case management, individualized medication adherence services, mental health and substance abuse services, nutrition counseling, individualized HIV education, laboratory testing, and radiology services. WHIC's providers include three board-certified/board-eligible Infectious Disease specialists as well as an Advanced Practitioner Nurse and a Registered Dietician, all with expertise in the management of patients with HIV/AIDS. In FY 2012, WHIC served around 500 People Living with HIV/AIDS (PLWHA).

WHIC's staff members actively participate in statewide and area collaboratives, such as the Connecticut HIV Planning Consortium (CHPC) and the Ryan White Part A Planning Council, and WHIC facilitates the Greater Waterbury HIV Consortium. WHIC has a very active Consumer Advisory Group (CAG), which organizes social and testing events for the community and facilitates the Waterbury Hospital Photography Group.

The WHIC also has a Hepatitis C clinic, run by an Advanced Practitioner Nurse. From October 2004 to Present, nearly 200 Hepatitis C mono- and co-infected (Hepatitis C and HIV) patients have been evaluated at the ID Clinic. The Hepatitis C clinic provides a consultation with a nutritionist to advise on healthy eating; coordination with mental health services; and educational sessions on side effect management, the importance of hydration and adherence, and positive coping strategies.

Be Well Bus
In order to ensure that patients have access to medical appointments, at the hospital and at local physicians' offices, Waterbury Hospital's Be Well Bus provides transportation services to patients from Waterbury and eleven of its surrounding towns. During FY 2012, the Be Well Bus completed over 4,170 transports to and from medical appointments. Waterbury Hospital has contracted with a transportation provide to offer the bus service, and area providers pay a small fee to participate.

Diabetes Disease Management (DDM) Clinic
The DDM utilizes a multidisciplinary case management approach to develop treatment plans and monitor patient progress. The DDM Clinic provides >150 diabetics with self-management skills and clinical care. The clinical team meets weekly on Wednesdays to develop treatment plans for new patients and collaborate on the progress of existing patients.

Evergreen 50 Club
Waterbury Hospital's Evergreen 50 Club is an organization comprised of over 15,000 members over the age of 50. The Club offers wellness programming, Medicare counseling, and health education presentations on a variety of topics are presented by health care professionals. Presentation topics include: holistic health, varicose vein treatment, heart disease, summer skin care, weight loss, blood pressure, bladder screenings, joint care and replacement, nutrition, and resolving adverse outcomes with patients and families. Annually, the Evergreen 50 Club hosts a health fair for its members, which provides free flu shots and healthcare screenings.

Family Birthing Center
Providing a child-centered focus, Waterbury Hospital's Family Birthing Center offers expectant parents a variety of classes to prepare them for their baby's arrival. Between breast feeding, childbirth, infant care classes, and nutritional presentations at our Family Birthing Center provided vital instruction to over 120 persons last year.

Heart Center of Greater Waterbury
Formed in collaboration with Saint Mary's Hospital, the Heart Center of Greater Waterbury provides diverse medical support initiatives to help educate residents in the Greater Waterbury community about pertinent health and wellness issues. This past year, the Heart Center conducted a series of health fairs and various health and wellness education sessions, including "Ask the Nurse," which provides patients with complimentary blood pressure screenings and health awareness education and a "Freedom from Smoking" series to help our residents kick the habit. During FY 2012, the Heart Center's programs served over 3,280 residents from the Greater Waterbury Area.

Thank God I'm Female
For the past 20 years, Waterbury Hospital's "Thank God I'm Female" has served as an annual women's wellness forum that features 40 educational booths and health-related giveaways. The ultimate goal of the forum is to educate attendees about stress, mental well-being, heart health, diet, healthy cooking, osteoporosis and bone health, change of life, and more. In 2012, over 400 area residents attended the event.

Waterbury Research Day
Through collaboration with St. Mary's Hospital in Waterbury, CT, Waterbury Hospital hosted its annual Waterbury Research Day. During the day, resident physicians, pharmacy residents, and medical students present research projects to the physician community. High school students are also encouraged to participate in the activities.

B. MENTAL HEALTH AND SUBSTANCE ABUSE

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase cultural competency among mental health and substance abuse providers
- Increase number of points of access for referral to services
- Reduce stigma of mental health and substance abuse disorders
- Increase community support structures and individual resiliency skills
- Increase the proportion of adolescents never using substances
- Reduce illegal substance use

Strategies:

1. Establish bi-annual education/family support seminars which would be available to clients, families and community members.

2. Expand student/intern program to provide clinical training rotations throughout the Department of Behavioral Health. Up to 5 academic year internships would be offered annually to master's level students pursuing education in addictions and mental health.

3. Initiate specialized programming on the inpatient adolescent unit to incorporate Dialectical Behavior Therapy (DBT) skills as well as goal setting to decrease the rates of seclusion and restraint.

4. Maximize resources within the Access Center to increase number of individuals served by 10% by providing assistance and "bridge" treatment to ensure continuity of care between services, and urgent/emergent assistance where needed to prevent decompensation and unnecessary hospitalization.

Existing Resources:

Behavioral Health

Waterbury Hospital's Behavioral Health Department is one of the region's largest service providers offering a full continuum of care for children, adolescents and adults. Our services also outreach to the community through regular participation in health fairs, elected membership in the Northwest Regional Mental Health Board, as a host site to numerous twelve-step meetings and the provision of case management as well as acute services to the homeless within the City of Waterbury.

Grandview Adult Behavioral Health
Grandview Adult Behavioral Health is the adult component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals ages eighteen and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; gender specific programming, cognitive therapy and DBT (Dialectical Behavior Therapy). Services provided in the Intensive Outpatient and traditional Outpatient Programs include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy

West Main Behavioral Health
West Main Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age eighteen and up who suffer from a variety of substance use disorders as well as concurrent psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; motivational interviewing, cognitive therapies and suboxone induction/maintenance.

Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, ambulatory detoxification, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, family therapy and multifamily therapy are also provided when clinically indicated. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Center for Geropsychiatry
The Center for Geropsychiatry is one of the adult components of the Behavioral Health Department ambulatory care service. Comprehensive psychiatric treatment is offered to individuals age sixty and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.

Services provided in the Outpatient Program include comprehensive psycho diagnostic assessment and evaluation, family therapy, group therapy, milieu therapy, and pharmacotherapy. Individual and Family Therapy is provided as needed.

Child and Adolescent Behavioral Health
Child and Adolescent Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age ten to eighteen who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders.

Limited outpatient services are provided to individuals aged 12-21 who are transitioning to outpatient and/or adult services. Intensive ambulatory services are organized to promote recovery from psychiatric disorders through active treatment outside of an inpatient setting. Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are also provided when clinically indicated. Transportation services are available to patients for partial hospital visits as needed. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Services provided in the Intensive Outpatient Program and Outpatient Service include comprehensive psycho diagnostic assessment and evaluation; group therapy; milieu therapy; and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are provided when clinically indicated.

Crisis Center/ Access Center

The Crisis Center provides urgent/emergent evaluations and short term treatment to all individuals presenting to the Emergency Department and/or Crisis offices with immediate and acute behavioral health needs. Consultation services are provides on the inpatient medical floors when ordered by an attending physician. Evaluative services are provided for any individual regardless of their age.

Services are provided to individuals who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, substance use disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.
Active collaboration and coordination of care occur with the patients, the crisis clinicians and community provides to ensure a smooth transition from crisis services to the next appropriate treatment setting.

Program hours are Seven days per week between 8 am and midnight. Services are open and available 365 days per year.

Center for Behavioral Health

Behavioral Health Services provided include psychiatric evaluations, OT/AT evaluations, family therapy, group therapy, didactic educational groups, individual counseling and recreational services all within a milieu framework offering twenty four hours services within an inpatient hospital setting. Inpatient services are available within separate subunits to adolescents (ages 12- 18) as well as adults age 18 and over. Diagnostic services are available when indicated within the general hospital and include clinical laboratory, radiology and medical/service allowing for comprehensive consultations.

Our efforts are aimed at promoting the benefits of clinical treatment as well as positive lifestyle choices. Every effort is made to educate clients, their families and the community about mental

illness and the impact treatment can have on one's illness. The ultimate goal is to help people feel better, reduce or resolve symptoms and to minimize the stigma of mental illness.

Support Groups
During 2012, Waterbury Hospital hosted several support groups for its patients and their families, including:

- Behavioral Health's parent and sibling support group, which offers emotional assistance to families who have children in treatment; and
- Alcoholics Anonymous, serves over 4,000 people annually, meets weekly throughout the year, and is coordinated by our Behavioral Health Department.

C. OVERWEIGHT AND OBESITY

Goal: Promote health and reduce chronic disease through healthy(ful) eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Increase access to and use of safe areas for physical activity
- Increase residents knowledge/awareness of a balanced diet and physical activity
- Reduce risk factors for chronic disease

Strategies:

1. The WH Wellness Committee initiates events and activities focused at supporting the physical and mental wellbeing of the WH staff and residents in the county. Initiatives include: (1) Establish a weekly Farmer's Market in conjunction with Waterbury's Brass City Harvest on Hospital grounds to increase access to and encourage consumption of healthful foods. (2) Establish a "Get Moving" program to encourage physical fitness for employees, patients, and community members.

2. Increase nutritional education within the child and adolescent Behavioral Health program as well as the implementation of a "low ropes" program to increase self-awareness, skill building, and physical fitness.

3. Increase the number of patients receiving nutritional counseling and self-management education at WH ID Clinic, and WH DDM Clinic by 10%. Referrals to the WH outpatient dietitian are made when clinically indicated.
4. Publish calorie counts for all foods in the WH Cafeteria by December 2014.

5. Conduct an employee health risk assessment in January 2015 to 100% of WH employees with health insurance through WH to encourage positive health engagement with a discount deductible incentive.

6. Expand the physical fitness program in collaboration with the Waterbury YMCA at the DDM Clinic to include 20 patients of the WH ID Clinic.

Existing Resources:

Nutritional Counseling
Patients admitted to WH (inpatient) are screened within 24 hours to assess for nutrition risk; those patients that are at high nutrition risk trigger a consult to the Registered Dietitian. MDs and other providers can order an RD consult for any patient they feel should be seen by an RD (including diet education). In addition, all patients of WH DDM Clinic and WH ID Clinic are seen by a Registered Dietitian and are provided with appropriate nutritional counseling and self-management training. Patients at both clinics are seen as often as necessary to teach nutrition concepts and help them to make desired lifestyle changes; these patients are seen at least annually.

Supporting Community Need
The WH ID Clinic runs a Food Pantry for HIV patients. WH also routinely responds to requests from the community through organized campaigns for specific items run by its employees ie the annual Thanksgiving Turkey drive in November and the annual Cereal drive in May, to help families prepare to feed children breakfast during the summer months when school is out.

Patient Fitness
The DDM Clinic has established an established an arrangement with the Greater Waterbury YMCA to provide monthly memberships to DDM patients to promote a regular exercise regime; 21 patients were referred from January through November 2012.

Employee Fitness
WH maintains an onsite Fitness Center for employee use, open 24 hours a day, seven days a week. Employees pay a one-time, $10 life-time membership fee. WH employees also receive a discount on Waterbury YMCA memberships. Additionally, WH supports on-line participation in Weight Watchers programs for its employees.

Community Fitness
The Evergreen 50 Club offers multiple 'keep fit' programs for community members and staff over 50 years old. Classes include Pilates and weight training.

D. TOBACCO USE

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Strategies:

1. Provide tobacco screening to 100% of patients and education to 100% of patients who smoke before their discharge from WH.
2. Increase tobacco screening and education to 100% of outpatients seen in the primary care medical practice for continuity visits at the Chase Outpatient Center. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
3. Screen 100% of patients in the WH ID Clinic for tobacco use. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
4. Participate in the American Lung Foundation's annual 'Great American Smoke Out' program through the WH Wellness Committee.

Existing Resources:

WH successfully transitioned to a Tobacco free campus in November 2010.

Tobacco screening is provided to 100% of patients in the WH Behavioral Health Department and education is provided to 100% of patients who tobacco users. Resource information on smoking cessation is provided in all patient waiting areas.

WH is collaborating with the Regional Mental Health Board and will be providing smoking cessation groups along with one to one telephonic coaching.

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Waterbury Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Waterbury Hospital Board of Directors met on September 26, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the **2013 Waterbury CHNA Final Report**, the **2013 CHNA WH Implementation Plan**, and the **2013 CHNA WH Implementation Plan Summary**, and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT 7

Saint Francis *Care* ~ Service Lines and Support Platforms

Service Lines

- Behavioral Health
- Cardiovascular
- Connecticut Joint Replacement Institute
- Emergency Medicine & Pre-Hospital
- Medicine
- Oncology
- Physical Medicine & Rehabilitation
- Primary Care
- Surgery
- Women & Children

Support Platforms

Clinical
Care Coord / Case Mgt
Critical Care
Diagnostics
Infection Control
Informatics
Nursing Practice
Pastoral Care
Patient Liaisons
Pharmacy
Quality / Risk Mgt

Business & Services
Business Development
Compliance
Enterprise Risk Mgt
Finance / Audit
Government Relations
Human Resources
Information Technology
Legal / Regulatory
Marketing / Comm
Mission Integration
Strategic Planning
Supply / Materials Mgt

Innovation & Learning
Education
Innovation
Leadership Development
Library
Performance Improvement
Research
SFC Solution System
Simulation

Facilities
Biomedical
Engineering
Food Services
Housekeeping
Laundry
Security
Space Management
Transport

focus on Patient Experience runs through all

EXHIBIT 8

SFC Alliance Approach

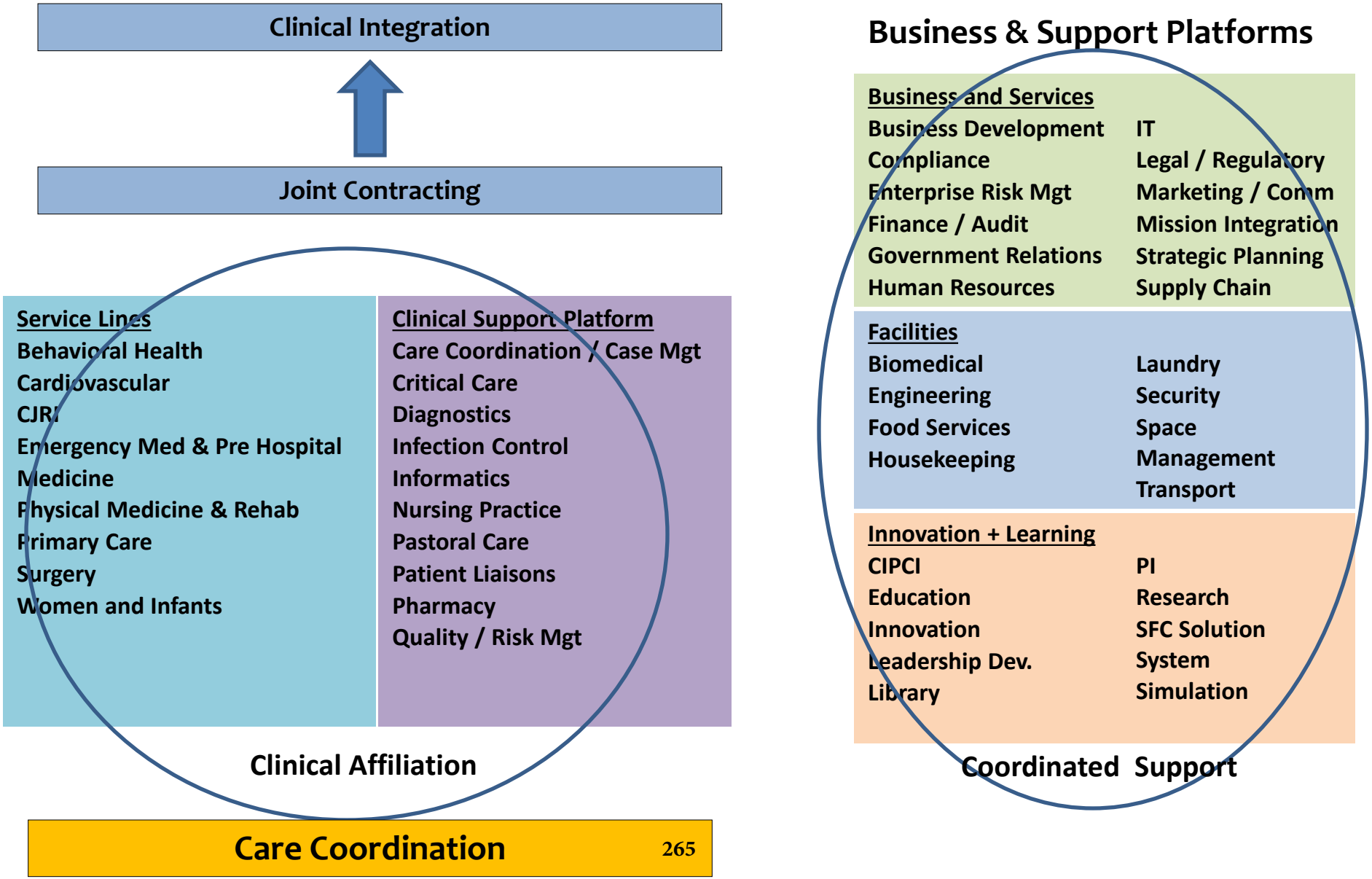


EXHIBIT 9

Saint Francis *Care* Awards and Recognitions

NCDR ACTION Registry – GWTG Platinum Award – Saint Francis has received the American College of Cardiology's NCDR ACTION Registry–GWTG Platinum Performance Achievement Award for 2015. Saint Francis *Care* is one of only 319 hospitals nationwide to receive the honor. The award recognizes Saint Francis's commitment and success in implementing a higher standard of care for heart attack patients and signifies that Saint Francis has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations. (July 2015)

Most Wired – 2015 – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2015 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the sixth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2015)

US News & World Report/Best Hospitals for Common Care – Saint Francis was recognized as "High Performing" for the treatment of COPD and Knee Replacement. (June 2015)

Premier Inc., Diversity Award – Saint Francis *Care* received the *Diversity Award* at Premier's annual Breakthroughs Conference and Exhibition. The *Diversity Award* honors health systems that have established active programs to evaluate and support minority-, women- and veteran-owned enterprises, as well as small businesses, available through the Premier contract portfolio. (June 2015)

American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award – Saint Francis Hospital and Medical Center has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation's secondary prevention guidelines for patients with heart failure. This marks the sixth year that Saint Francis has been recognized with this award. Saint Francis also received the association's *Target: Heart Failure Honor Roll.* This initiative provides hospitals with educational tools, prevention programs and treatment guidelines designed to reduce the risk of heart failure patients ending up back in the hospital. Saint Francis is the only hospital in the state to earn the *Target: Heart Failure Honor Roll* distinction. (June 2015)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2015)

Associated Builders and Contractors Excellence - Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 2015)

Becker's Hospital Review – Becker's Hospital Review a leading source of information for healthcare professionals, has listed Saint Francis Hospital and Medical Center among the top 100 hospitals in the country with "great women's health programs." Hospitals were selected for the list based on clinical accolades and recognition for women's health excellence from various healthcare groups and agencies. Those agencies include U.S. News & World Report, Healthgrades, CareChex and UNICEF's Baby-Friendly Hospital Initiative. Saint Francis was one of three hospitals in Connecticut named to the list, along with Hartford Hospital and Yale-New Haven Hospital. (December 2014)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 30, 2015)

Associated Builders and Contractors Excellence - Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 29, 2015)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2015 *Best Hospitals for Patient Safety*. The award is based on consistently low rates of infections and surgical errors, and patient recommendations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (December 3, 2014)

The LeapFrog Group "A" Score –Saint Francis *Care* has again received an "A" rating Hospital Safety Score℠ from the Leapfrog Group, a national hospital quality watchdog organization. The Leapfrog Group has released its fall 2014 Hospital Safety Scores. For the 6th consecutive time Saint Francis has received an "A" rating. Saint Francis is one of only four hospitals in the state to earn the highest rating and the only Connecticut hospital to receive the "A" rating in both the fall and the spring. Six hospitals received "B" ratings; 12 a "C" rating; and three a "D" rating in the recent rankings. Overall, Connecticut ranked 33rd out of 42 states, with just 16% of its 25 rated hospitals receiving an "A" grade. The Hospital Safety Score℠ for 2014 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. The grades are derived from analysis of publicly available data using 28 evidence-based, national measures of hospital safety. (November 2014)

CareChex – Saint Francis Hospital and Medical Center has also been recognized by CareChex®, a division of Comparion Medical Analytics, for national and state medical excellence achievements in numerous categories in its 2015 hospital quality award rankings. Saint Francis was ranked

90th nationwide for overall medical excellence in hospital care among nearly 4,200 hospitals reviewed, and was the only Connecticut hospital to score in the top 100.

The Hospital also ranked nationally among the hospitals reviewed as:

- #5 in coronary bypass surgery (out of 1,196 hospitals scored)
- #8 in joint replacement (out of 3,497 hospitals scored)
- #9 in major orthopedic surgery (out of 3,499 hospitals scored)

In addition, Saint Francis ranked #1 in Connecticut in the following eight clinical and surgical areas:

- Overall Hospital Care – Medical Excellence
- Overall Surgical Care – Medical Excellence
- General Surgery – Medical Excellence
- Joint Replacement – Medical Excellence
- Neurological Surgery – Medical Excellence
- Orthopedic Care – Medical Excellence
- Orthopedic Surgery (Major) – Medical Excellence
- Spinal Surgery – Medical Excellence

(November 2014/For internal non-commercial use only.)

Healthgrades® – Saint Francis *Care* has been recognized for clinical excellence in a national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *2015 Quality Achievements Report:*

- *Saint Francis Care earned the Distinguished Hospital Award for Clinical Excellence in 2015. (Embargo January 20, 2015)*
- *100 Best Hospitals for Coronary Intervention, 2 years in a row*
- *Coronary Intervention Excellence Award, 2 years in a row*
- *Top 10% in the Nation for Coronary Interventional Procedures*
- *Recipient of the Healthgrades Stroke Care Excellence Award*
- *Top 10% in the Nation for Treatment of Stroke*
- *100 Best Hospitals for Joint Replacement, 3 years in a row*
- *100 Best Hospitals for Orthopedic Surgery, 2 years in a row*
- *Joint Replacement Excellence Award, 3 years in a row*
- *Orthopedic Surgery Excellence Award, 2 years in a row*
- *Top 5% in the Nation for Joint Replacement, 3 years in a row*
- *Top 5% in the Nation for Overall Orthopedic Service, 2 years in a row*

Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: coronary intervention procedures, treatment of heart attack, coronary bypass surgery, treatment of stroke, repair of abdominal aorta, total knee replacement, total hip replacement, and for spinal fusion surgery. (DHACE, January 20, 2015; Specialty Excellence Awards, October 21, 2014)

Becker's Hospital Review – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "125 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is one of only two Connecticut hospitals on the list. This is the fifth year Becker's Hospital Review has compiled this list, and the first time it has included 125 hospitals. (September 2014)

Joint Commission's Gold Seal of Approval/Stroke Center Accreditation – Saint Francis Hospital and Medical Center has earned *The Joint Commission's Gold Seal of Approval®* for accreditation of its Stroke Center by demonstrating compliance with The Joint Commission's national standards for healthcare quality and safety. The accreditation award recognizes Saint Francis's dedication to continuous compliance with state-of-the-art standards in its primary care stroke center operations. (August 2014)

U.S. News & World Report – In a national survey of 4,806 hospitals, Saint Francis Hospital and Medical Center was one of 752 hospitals to achieve at least one "High Performing" rating among 16 medical specialties in the 25th annual U*.S. News & World Report* ranking Best Hospitals in the U.S. Saint Francis was recognized as high performing in 9 specialties: Cardiology and Heart Surgery; Ear, Nose and Throat; Gastroenterology and GI Surgery; Geriatrics; Nephrology; Neurology and Neurosurgery; Orthopedics; Pulmonology; and Urology. (July 2014)

LifeChoice Donor Services – Saint Francis Hospital and Medical Center earned a gold award for their work with LifeChoice Donor Services. LifeChoice Donor Services is among a select group of organ procurement organizations (OPOs) nationwide recognized by the U.S. Department of Health and Human Services (HHS) for reaching gold, silver, and bronze levels of achievement for conducting activities that promote enrollment in state organ, tissue and eye donor registries. The hospitals are part of a national hospital campaign, sponsored by HHS's Health Resources and Services Administration (HRSA), which has added 327,659 donor enrollments to state registries nationwide since 2011, exceeding the goal of 300,000. (July 2014)

American Diabetes Association – The American Diabetes Association Education Recognition Certificate for a quality diabetes self-management education program was recently awarded to the Center for Diabetes and Metabolic Services at Saint Francis. The designation assures that programs meet the national standards for Diabetes Self-Management Education Programs. (July 2014)

Most Wired – 2014 – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2014 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the fifth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2014)

Healthgrades: Patient Safety & Women's Health Excellence Awards – **Saint Francis Hospital and Medical Center** received the *2014 Patient Safety Excellence Award™* and the *Women's Health Excellence Award*, from Healthgrades, the leading online resource for comprehensive information about physicians and hospitals. (June 2014)

- *The Patient Safety Excellence Award* distinction places Saint Francis within the top 10% of all hospitals for its excellent performance in safeguarding patients from serious,

potentially preventable complications during their hospital stays. This is the fourth consecutive year that Saint Francis has received this award, and one of only two Connecticut hospitals to earn the distinction this year.

- The *Women's Health Excellence Award* distinguishes Saint Francis as a top-performing hospital in women's health. Saint Francis is one of only 178 recognized nationally for their outcomes for care provided to women for common conditions and procedures treated in the hospital. Saint Francis is on the only hospital in Connecticut to earn this distinction.

Premier Supply Chain Excellence Award – Saint Francis Hospital and Medical Center has received *Premier, Inc.'s Supply Chain Excellence Award* for superior supply expense performance. Saint Francis is one of only 35 Premier members to receive the award this year. Premier, a leading healthcare improvement company, unites an alliance of approximately 3,000 U.S. hospitals and 110,000 other providers. (Embargo Date: June 11, 2014)

American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award – Saint Francis has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation secondary prevention guidelines for heart failure patients. This marks the third time that Saint Francis has been recognized with a quality achievement award. (May 2014)

The LeapFrog Group "A" Score – Saint Francis Hospital and Medical Center has again received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. This is the 5th consecutive "A" rating received by Saint Francis from The Leapfrog Group. Saint Francis was one of two hospitals in the state to receive an "A" grade from Leapfrog in the latest rating for spring 2014, and the only hospital to receive the "A" rating in both the fall and spring. Among the 25 Connecticut hospitals, 8 received a "B," 13 received a "C," one received a "D," and one received an "F." Scores went down for four hospitals, while three hospitals improved their scores. (April 2014)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2014 Best Hospitals for Patient Experience in Heart Care. The award is based on robust criteria that include female patient satisfaction measurements as well as clinical excellence considerations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2014)

Becker's Hospital Review – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "100 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is the only Connecticut hospital on the list. (January 2014)

Becker's Hospital Review– Saint Francis Hospital and Medical Center was named on the Becker's Hospital Review list of *100 Hospitals with Great Heart Program*. Becker's rates hospitals based on recognition for quality care, clinical awards and research contributions to cardiovascular care. (December 2013)

Alliance of Independent Academic Medical Centers (AIAMC) – Saint Francis *Care* received the *2014 Innovation Award* from the Alliance of Independent Academic Medical Centers (AIAMC) in recognition of the innovative medical education programs for residents, physicians and staff that have resulted in better patient outcomes. This is the second time the Hospital received the Innovation Award. (December 2013)

Association of American Medical Colleges – The Innovation + Learning Center at Saint Francis was one of national 13 recipients to receive the *Association of American Medical Colleges Learning Health System Challenge and Planning Award*, which recognizes innovations in medical education, care delivery, research, and diversity and inclusion. At Saint Francis, the award was given for emphasis on studying efforts to improve everyday clinical practice and health equity in an accountable care environment across the system. (December 2013)

Healthgrades® – Saint Francis *Care* was recognized for clinical excellence in a new national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *American Hospital Quality Outcomes 2014: Healthgrades Report to the Nation*, which evaluates hospital performance at over 4,500 hospitals nationwide for 31 of the most common inpatient procedures and conditions. Saint Francis ranks among the top 5% nationally in Coronary Interventional Procedures, Overall Orthopedic Services, and, for the second year in a row, Joint Replacement; and the top 10% for Spine Surgery. (October 2013)

The LeapFrog Group "A" Score – Saint Francis Hospital and Medical Center has received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. The Hospital Safety Score℠ for fall 2013 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. This is the fourth consecutive "A" rating received by Saint Francis from The Leapfrog Group. The grades are derived from expert analysis of publicly available data using 28 evidence-based, national measures of hospital safety. Saint Francis was one of three hospitals in the state to receive an "A" grade from Leapfrog in the rating for fall 2013, and one of only two to receive the honor twice this year. Among Connecticut hospitals, 7 received a "B," 15 received a "C," one received a "D," and one received an "F." (October 2013)

Daily Point of Light Award – Points of Light, the world's largest volunteer organization, named Michael R. Bourque, M.D., a senior OB/GYN physician at Saint Francis Hospital and Medical Center, a *Daily Point of Light Award* honoree for his leadership role on the "Blue Team," a medical missionary team with International Medical Missions of Saint Francis Hospital and Medical Center. Dr. Bourque is the recipient of this prestigious award honoring his commitment to bringing first-class medical services to those in need. (October 2013)

CareChex® – Saint Francis Hospital and Medical Center was recognized by CareChex®, a division of Comparion Medical Analytics, for patient safety and medical excellence achievements in numerous categories in its 2014 hospital quality award rankings. Saint Francis ranked #1 in Connecticut in 24 clinical and surgical areas for patient safety and medical excellence. In the area of Patient Safety: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Coronary Bypass Surgery, Gastrointestinal Care, Gastrointestinal Hemorrhage, Interventional Coronary, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, and Major Orthopedic

Surgery. For Medical Excellence: Overall Hospital Care, Overall Surgical Care, Coronary Bypass Surgery, Gastrointestinal Care, General Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Orthopedic Care, Major Orthopedic Surgery, Spinal Fusion, and Spinal Surgery. (October 2013)

IBCLC Care Award – Saint Francis Hospital and Medical Center received *IBCLC Care Award* from the International Board of Lactation Consultant Examiners® (IBLCE®) and International Lactation Consultant Association® (ILCA®) for excellence in lactation care. The recognition is given to facilities that: have a lactation program that is available 5-7 days a week; provided recent breastfeeding training for medical staff; and have recently completed activities that help protect, promote, and support breastfeeding. (August 2013)

American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award* – Saint Francis Hospital and Medical Center received the *Get With The Guidelines®–Heart Failure Gold Plus Quality Achievement Award* from the American Heart Association. The recognition signifies that Saint Francis has reached an exceptional goal of treating heart failure patients according to the guidelines of care recommended by the American Heart Association/American College of Cardiology. This marked the second consecutive year that Saint Francis has been recognized with the *Gold Plus* quality achievement award. Saint Francis was one of just three hospitals in Connecticut to receive *Gold Plus* recognition that year. (August 2013)

Consumer Reports – *"Best Hospital for Surgery"* – Saint Francis Hospital and Medical Center was one of two statewide hospitals to receive the highest ranking available by Consumer Reports Health Ratings Center in their *"Best Hospitals for Surgery"* Ratings report appearing in the September 2013 issue of Consumer Reports magazine. Of the almost 2,500 hospitals rated by Consumer Reports in all 50 states plus Washington, D.C. and Puerto Rico, Saint Francis Hospital and Medical Center received not only the highest overall surgery Rating in state rankings, it was also named among the top five U.S. hospitals that perform the safest knee and hip replacement surgeries, and the only hospital rated in these two categories in the state. (July 2013)

Most Wired – 2013 – Saint Francis Hospital and Medical Center was recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2013 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. Named to the *Most Wired* list for the fourth consecutive year, Saint Francis is one of only eight hospitals in Connecticut to be recognized on the *Most Wired* list that year. (July 2013)

U.S. News & World Report – Best Hospitals – Saint Francis Hospital and Medical Center ranked #3 in the state of Connecticut and #2 in the Hartford metro area, gaining high scores in eight specialties and in patient safety, in the *U.S. News & World Report* ranking of Best Hospitals in the U.S. Top performing specialties at Saint Francis listed in the *U. S. News & World Report* annual rankings of Best Hospitals include Cardiology and Heart Surgery, Diabetes and Endocrinology; Gastroenterology and GI Surgery, Geriatrics, Nephrology, Orthopedics, Pulmonology and Urology. (July 2013)

The LeapFrog Group "A" Score – For the third consecutive year, Saint Francis Hospital and Medical Center was again honored with an "A" Hospital Safety Score by The Leapfrog Group, an independent national nonprofit run by employers and other large purchasers of health benefits.

The A score was awarded in the latest update to the Hospital Safety Score℠. The A, B, C, D or F scores are assigned to U.S. hospitals based on preventable medical errors, injuries accidents, and infections. The Hospital Safety Score was compiled under the guidance of experts on patient safety and is designed to give the public information they can use to protect themselves and their families. (May 2013)

HealthGrades® Patient Safety Excellence Award™ – Saint Francis Hospital and Medical Center received the *Healthgrades 2013 Patient Safety Excellence Award™*, according to Healthgrades, the leading online resource that helps consumers search, evaluate, compare and connect with physicians and hospitals. The distinction placed Saint Francis within the top 5% of all hospitals for its excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays. This was the third consecutive year that Saint Francis received this prestigious award. Saint Francis was the only hospital in Connecticut to achieve this distinction in 2013. (April 2013)

Practice Greenhealth/Partner for Change Award – for leadership in prioritizing our environmental performance and demonstrating our commitment to a higher standard of excellence in sustainability. This is the fifth time Saint Francis earned this distinction. (April 2013)

CareChex – According to a 2011 CareChex national hospital quality study, Saint Francis Hospital and Medical Center was #1 in the State in the category of "Medical Excellence" for: Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Orthopedic Care, Major Orthopedic Surgery, Spinal Surgery, and Trauma Care. Additionally, Saint Francis was #1 in the State for Patient Safety in the areas of: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Major Orthopedic Surgery, Stroke Care, and Trauma Care. (January 2013)

The LeapFrog Group "A" Score – *Saint Francis Hospital and Medical Center* was honored with a second consecutive "A" Hospital Safety Score℠ by The Leapfrog Group, a nationally recognized organization founded by a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers nationwide. Saint Francis was the largest hospital in Connecticut to merit this distinction, and one of only six statewide to receive this recognition. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety records. (November 2012)

Connecticut Breastfeeding Coalition – Saint Francis Hospital and Medical Center received an award of recognition from the Connecticut Breastfeeding Coalition for its contributions to the health of Connecticut's mothers and children through the Connecticut Breastfeeding Initiative 2010-2012. (October 2012)

Healthgrades® – Saint Francis *Care* was listed as #1 in Connecticut for joint replacement outcomes and is one of America's 100 Best Hospitals for Joint Replacement. Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: heart failure, back and neck surgery, stroke, pneumonia, GI bleed, respiratory failure, diabetic

acidosis and coma. This is according to a report from Healthgrades, *American Hospital Quality Outcomes 2013: Healthgrades Report to the Nation*. Healthgrades is the leading provider of information to help consumers make an informed decision about a physician or a hospital. (October 2012)

HAVEN Employer Engagement Award – this award was presented to Saint Francis by the Health Assistance InterVention Education Network (HAVEN). The award recognized employers who, through human resources, employee assistance, and/or occupational health, have developed ways to help employees confront the challenges of physical and mental illness with dignity and compassion. (October 2012)

"I Am Who I Am" – recognized by the Walk In the Light Ministries and by Archbishop Louella Tate as an organization that has helped Hartford become a role model for other cities. (September 2012)

National Air Filtration Association (NAFA) Clean Air Award – recognized for leadership and excellence in the use of high efficiency air filtration products and good maintenance practices. It is presented to those who show an outstanding effort in maintaining a clean and healthy indoor work environment, while reducing overall operating costs. (September 2012)

***Most Wired* – 2012** – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2012)

Connecticut Quality Improvement Award Gold Prize – given to Saint Francis Hospital by the Connecticut Quality Improvement Association for our work in improving the Universal Protocol in our operating room, using the Safe Surgery Checklist. (June 2012)

The LeapFrog Group "A" Score –Saint Francis Hospital and Medical Center was only one of four hospitals in the state to receive an "A" grade on the organization's Hospital Safety Score. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety. (June 2012)

HealthGrades® Patient Safety Excellence Award™ – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates, placing Saint Francis in the top 5% in the nation for patient safety, and the only Connecticut hospital to achieve this distinction. (May 2012)

American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award* – to the Hoffman Heart and Vascular Institute for providing excellent care to heart failure patients. Saint Francis was one of only three hospitals statewide to receive this award. (May 2012)

***Silver Healthy Hospital Award*, Stryker** – for outstanding performance in reducing environmental harm and improving overall hospital quality through medical device remanufacturing and reprocessing. For 2011, Saint Francis saved $235,600 and had a total waste avoidance of 11,900 pounds. (April 2012)

Outcome Excellence Award – the outpatient rehabilitation staff at 95 Woodland Street received this award from Focus on Therapeutic Outcomes (FOTO) for exceeding the predicted national target for outcomes and patient satisfaction over a one-year period. The targets were met for two consecutive years, for both 2010 and 2011. (April 2012)

2012 Top Performer – the inpatient rehabilitation team at Mount Sinai Rehabilitation Hospital received an Outstanding Performance Award from the Uniform Data Systems database for its top ten percent ranking out of 800 programs across the United States. (April 2012)

The Blue Ribbon Award – for the John T. O'Connell Tower presented at the 17th Annual Awards Showcase from the Real Estate Exchange. This is the most significant annual awards event in commercial real estate in Connecticut and a celebration of excellence in the industry. (April 2012)

The BUILDCT 2012 Award – for the John T. O'Connell Tower best new large construction project greater than $10 million from the Association of General Contractors. The award was given to Saint Francis Hospital and Medical Center; TRO/Jung Brannen, the architect and engineer; and Turner Construction Company, the construction manager. (March 2012)

Connecticut Quality Improvement Award Silver Innovation Prize – for the creation of the Connecticut Institute for Primary Care Innovation. (August 2011)

American Heart Association/American Stroke Association Get With The Guidelines Gold Plus Award – for achievement in using evidence-based guidelines in the treatment of stroke patients. (August 2011)

Most Wired – 2011 – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2011)

Community Value Five-Star Hospital – recognized by Cleverly & Associates, a healthcare industry intelligence and education consultancy for value provided to the community, based on financial viability, facility reinvestments, low-cost structures, and high-quality patient care. (July 2011)

Practice Greenhealth Partner for Change with Distinction – for outstanding environmental achievement in healthcare. (April 2011)

HealthGrades® Patient Safety Excellence Award™ – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates. (March 2011)

The American Society for Metabolic and Bariatric Surgery and the Surgical Review Corporation Bariatric Surgery Center of Excellence® Designation – for demonstrating an unparalleled ability to consistently deliver safe, effective, evidence-based care. (March 2011)

Focus on Therapeutic Outcomes, Inc. Outcomes Excellence Award – for exceeding the national average for functional change in the patients treated at the Center for Rehabilitation and Sports Medicine. (March 2011)

The American College of Cardiology Foundation NCDR ACTION Registry Gold Performance Award – for implementing a higher standard of care and reaching the aggressive goal of treating coronary artery disease patients with 85 percent compliance with American College of Cardiology/American Heart Association clinical guidelines and recommendations. (December 2010)

The American Alliance of Healthcare Providers Choice Award – for implementing an excellent healthcare program that successfully results in courteous, compassionate, and caring service to patients, families, and the community. (July 2010)

Most Wired "Most Improved" Award – for the Hospital's level of achievement in business and administrative management, clinical quality and safety, continuum of care, and infrastructure. Based on a survey by *Hospitals & Health Networks* Magazine, McKesson Corporation and the College of Healthcare Information Management Executives. (July 2010)

Practice Greenhealth Partner for Change Award – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2010)

Anthem Blue Cross and Blue Shield Blue Distinction Center for Knee and Hip Replacement – In recognition of clinical excellence in knee and hip replacement surgery. (January 2010)

American Heart Association/American Stroke Association *Get With The Guidelines Gold Plus Performance Achievement Award* – In recognition of implementing excellent care for stroke patients, according to evidence-based guidelines. (January 2010)

U.S. Department of Health and Human Services Silver-2 Medal – In recognition of efforts promoting organ donation. (October 2009)

Employer Support of the Guard and Reserves Program – Connecticut Above and Beyond Award for support of Hospital employees who are members of National Guard and Reserves. (July 2009)

Practice Greenhealth Partner for Change Award – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2009)

ENERGY STAR Label – for superior energy efficiency and environmental protection. Awarded by the U.S. Environmental Protection Agency. Saint Francis was previously awarded ENERGY STAR labels in 2003 and 2006. (April 2009)

Connecticut Breastfeeding Coalition Breastfeeding Friendly Employer Award – Given for Saint Francis' efforts in supporting breastfeeding by working mothers. (January 2009)

American Stroke Association Get with the Guidelines℠ Silver Achievement Award – Given in recognition of Saint Francis' commitment and success in implementing a higher standard of care for stroke patients. To achieve the GWTG-Stroke Silver Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 12 months. (December 2008)

UnitedHealthcare Premium® Specialty Center for Total Joint Replacement – Given with the designation of ***One Star*** and ***Higher Efficiency***. The program uses national industry standards, medical specialty society and consensus standards to evaluate specialty center programs focused on total joint replacement for the purpose of advancing safe, timely, effective, efficient, equitable and patient-centered care. (September 2008)

American Alliance of Healthcare Providers Hospital of the Year – Top 10 Finalist in 2008 Hospital of the Year Awards, which recognizes the country's most consumer-friendly hospitals. (August 2008)

HealthGrades® 2009 Spine Surgery Excellence Award – This award places Saint Francis among the top 10 percent of hospitals nationwide for spine surgery. (July 2008)

2008 Most Wired Survey and Benchmarking Study – Most Improved Award for information technology enhancements in the survey conducted by *Hospitals & Health Networks* magazine in conjunction with Accenture, McKesson Corp. and the College of Healthcare Information Management Executives. (July 2008)

Connecticut Quality Improvement Award Silver Innovation Prizes – Three awards for projects that streamlined critical areas of healthcare: the treatment of heart attacks, transferring patients from the Emergency Department to nursing units, and vaccinating staff against season influenza outbreaks. (July 2008)

American Stroke Association Get With the Guidelines℠ – Stroke Bronze Performance Award – for Saint Francis' commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations. To achieve the GWTG-Stroke Bronze Performance Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 90 days. (May 2008)

Practice Greenhealth Partner for Change Award – for working to reduce mercury, reduce waste and prevent pollution. Presented by Practice Greenhealth, formerly Hospitals for a Healthy Environment (H2), a source of environmental solutions for the healthcare industry. The award honors organizations creating healthy, healing environments committed to eliminating mercury, reducing pollution and recycling waste. (May 2008)

2008 Alliance Innovation Award – Saint Francis Hospital and Medical Center was named an *Alliance Innovation Award* winner by the Alliance of Independent Academic Medical Centers (AIAMC). The award was presented to Saint Francis for its demonstrated leadership in utilizing graduate medical education as a key driver to improve quality, patient safety, and the cost-effectiveness of care. These creative and innovative approaches to medical education and research have resulted in better patient outcomes. (April 2008)

American Alliance of Healthcare Providers 'Hospital of Choice' Award for First Quarter of 2008 – for consumer friendliness and unparalleled commitment to good citizenship and community service, based on a review of public information, Web site, news releases, announcements, phone surveys of Hospital staff and application review. (April 2008)

Verispan 100 Most Highly Integrated Healthcare Networks Best of the Rest – a Tier 2 category rating for integrated healthcare networks based on eight categories: integrated technology, contractual capabilities, outpatient utilization, financial stability, service and access, hospital utilization and physicians. (February 2008)

United Healthcare Premium Specialty Center – for cardiac care, spine and total joint replacement surgery. The designations signify that Saint Francis has met rigorous quality criteria based on nationally recognized medical standards and expert advice. They are based on detailed information about specialized training, practice capabilities and proficiencies submitted by Saint Francis to United Healthcare. (January 2008)

CQIA Silver Innovation Prize – for being early adopters of bar code point of care (BPOC) technology to prevent errors during medication administration. BPOC systems use a bedside computer and a variety of clinical information systems to cross check bar codes that are printed on patient wristbands with those bar codes printed on medications. In addition to new bedside technology, the BPOC involved an extensive process within the Pharmacy Department. All 2,800 inventoried products required bar code recognition by the Hospital's clinical information system. In the first six months after implementation, 75 percent of inpatient areas were using this technology and 350,000 medication doses had been bar coded. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (October 2007)

U.S. Department of Health and Human Services Medal of Honor – for achieving at least a 75 percent organ donation rate among eligible patients. This was the third year in a row that Saint Francis received this award. Saint Francis is the only hospital in Connecticut and Western Massachusetts to receive the medal three years in a row. (October 2007)

AHA Nova Finalist – Hartford Regional Lead Treatment Center and Lead Safe House Program, which are based at Saint Francis Hospital and Medical Center, named one of ten finalists for the American Hospital Association's Nova Award, which recognizes programs that improve community health status and are collaborative in nature. The Hartford Regional Lead Treatment Center serves patients both at Saint Francis and the Connecticut Children's Medical Center. (August 2007)

Blue Center of Distinction – designated a *Blue Center of Distinction for Cardiac Care* by the Blue Cross and Blue Shield Association. The nationwide program recognizes those hospitals that meet stringent quality criteria, as established by expert physician panels and national organizations. *Blue Distinction Centers* are required to provide a full range of cardiac services, including inpatient care, cardiac rehabilitation, angioplasty and cardiac surgery. (June 2007)

Hospitals for a Healthy Environment – received the Partners for Change Award in recognition of achievements in improving environmental performance. Also received the Making Medicine Mercury-Free Award for eliminating the use of mercury in medical devices. Hospitals for a

Healthy Environment (H2E) is an independent, not-for-profit organization founded by the American Hospital Association, the Environmental Protection Agency, Health Care Without Harm and the American Nurses Association. H2E is focused on improving healthcare environmental performance. (May 2007)

Five-Star Hospital – recognized as a Community Value Provider by Cleverly + Associates, a Columbus, Ohio, healthcare financial consulting firm. Based on the Community Value Index™, a proprietary index that offers a measure of the value that a hospital provides to its community based on financial strength and reinvestment, cost of care and pricing. (April 2007)

The President's Volunteer Service Award – for the service of more than 700 individuals who volunteered at the Hospital in 2006, contributing over 67,400 hours of service to Saint Francis. Presented by the President's Council on Service and Civic Participation on behalf of President George W. Bush to recognize the best in the American spirit and encourage Americans to contribute to their communities through volunteer service. (January 2007)

CareScience Select Practice National Quality Leader – for excellence in overall hospital quality and efficiency. The award placed Saint Francis among the top 1 percent of performers across 4,500 acute care hospitals in the United States as identified by CareScience, a hospital consulting firm. It was based on 16 clinical indicators for both quality and efficiency. (November 2006)

ENERGY STAR Label – for prudent energy management strategies and proven technologies. Awarded by the U.S. Environmental Protection Agency and U.S. Department of Energy. Saint Francis was first awarded an ENERGY STAR label in 2003. (November 2006)

eHealthcare Strategy & Trends Silver Award – in the category "Best Rich Media" in the Physician/Clinician-Focused Site class for the Hospital's web site Grand Rounds Online feature. Since their introduction in April, 15 Grand Rounds presentations were made available to physicians online. After viewing a presentation online, physicians are able to obtain Continuing Medical Education credit by successfully completing a short quiz. (November 2006)

U.S. Department of Health and Human Services Medal of Honor – for achieving at least a 75 percent organ donation rate among eligible patients. This was the second year in a row that Saint Francis received this award. In the most recent reporting period, Saint Francis secured permission from family members for 11 organ donations out of 13 potential donors. Saint Francis was just one of two hospitals in Northern Connecticut and Western Massachusetts to receive the medal this year. (October 2006)

HealthGrades® Orthopedic Surgery Excellence Award – for superior clinical outcomes in the ninth annual *Hospital Quality in America* study. This award placed Saint Francis among the top 10 percent of hospitals nationwide for orthopedic care. (October 2006)

Leapfrog Top 50 Hospitals – for meeting the quality and safety standards of the Leapfrog Group, a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers. Saint Francis was the only hospital in Connecticut to achieve this distinction. Leapfrog identifies its "Top Hospitals" based on their implementation of practices with the greatest life-saving potential, including computerized physician order entry

(CPOE), ICU physician staff, evidence-based hospital referral and the Leapfrog Safe Practices Score. (October 2006)

2006 BEACON Medical Technology Award – for the Hospital's significant investment in advanced technology in the acquisition of the CyberKnife® stereotactic radiosurgery system. The award was presented by the Biomedical Engineering Alliance & Consortium (BEACON), a regional trade association for the advancement of new medical technology. It recognizes innovative approaches that help Connecticut establish a leadership position in the field of medical technology. (October 2006)

Sacred Heart University College of Education and Health Professions 2006 Community Partner Award – for collaboration with the College's Nursing Department to develop and implement the R.N. to B.S.N. program offered at Saint Francis Hospital and Medical Center. This was the first year that the award was given to an individual or organization who has demonstrated exceptional collaboration to further the educational goals and mission of the College. Saint Francis was one of two recipients honored that year. (October 2006)

HealthGrades® Third Annual Patient Safety in American Hospitals Study – for best performing hospitals for overall patient safety. Saint Francis was one of 238 hospitals identified as reaching the top 15 percent nationwide for patient safety. This award was presented by HealthGrades, a healthcare ratings company. As a category, Medicare patients at these top 15 percent hospitals experienced patient safety incidents, on average, 43.27 percent less often than patients at the bottom 15 percent of all hospitals. (October 2006)

CQIA Silver Innovation Prize – for a project that optimized care in patients with congestive heart failure (CHF). Taking note of the fact that each year nearly 900 patients are admitted to the Hospital with CHF, the Congestive Heart Failure Service decided to establish Connecticut's first dedicated unit to provide comprehensive care for CHF patients. Outcomes for patients treated on the CHF unit have been demonstrably better than those of other CHF patients. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (July 2006)

Solucient 100 Top Hospitals® Performance Improvement Leader – for improving faster and more consistently than its peer hospitals across the nation. Nine performance measures were examined including risk adjusted mortality and complications, average length of stay, expenses, profitability, cash-to-debt ratio, growth in percent of community served, tangible assets and risk adjusted patient safety index. Saint Francis was recognized as one of the hospitals that achieved the fastest rate of consistent annual clinical and organizational improvement over a five-year period. (April 2005)

Solucient 100 Top Hospitals® – for setting benchmarks for the industry in such areas as quality of care, efficiency, financial performance, growing community service and patient safety. This marked the seventh time that Saint Francis was named to the prestigious list of the nation's Top 100 hospitals. At the time, Saint Francis was the only hospital in Connecticut to be named to the Top 100 list on seven or more occasions. (February 2005)

Solucient 100 Top Hospitals® – for setting performance benchmarks across four critical areas: quality of care, operational efficiency, financial performance and adaptation to the environment. This marked the sixth time that Saint Francis had been named to the prestigious

list. At the time, Saint Francis was the only major teaching hospital to be named to the Top 100 list on six occasions. (May 2004)

Solucient Performance Improvement Leader – for developing consistent and effective organization-wide performance improvement across critical measures at a faster rate than other U.S. hospitals between 1997 and 2001. Those measures include quality of care, operational efficiency and financial performance. Among 123 major teaching hospitals included in the study, Saint Francis' cumulative scored placed it in the 99th percentile. This signifies that Saint Francis' rate of improvement over the five years was higher and more rapid than 98 percent of the other major teaching hospitals studied by Solucient. (March 2004)

EXHIBIT 10

RESOLUTIONS TO BE CONSIDERED
AT
A SPECIAL MEETING OF THE BOARDS OF DIRECTORS
OF
SAINT MARY'S HEALTH SYSTEM, INC.
AND
SAINT MARY'S HOSPITAL, INC.
TO BE HELD
ON
THURSDAY, SEPTEMBER 17, 2015

WHEREAS, Saint Mary's Health System, Inc. ("SMHS"), has been in negotiations with Saint Francis Care, Inc. ("SFC") and Trinity Health Corporation ("Trinity Health"), relating to a certain Transfer Agreement by and among SMHS, Saint Mary's Hospital, Inc. ("SMH"), and Trinity Health (the "Transfer Agreement"), pursuant to which SFC (which will become the New England Regional Health Ministry ("NE-RHM") following completion of its transaction with Trinity) will become the sole corporate member of SMHS and serve as SMHS's parent (the "Transaction"; capitalized terms used but not defined herein shall have the meanings ascribed to them in the Transfer Agreement);

WHEREAS, the Board of Directors of SMHS and the Board of Directors of SMH (together, the "Boards") have reviewed from a financial, business, healthcare, operational, strategic and community perspective the proposed Transaction and having given due consideration to all matters that the Boards believe are necessary or appropriate to enable the Boards to reach a fully informed decision as to the advisability of the Transaction, deem it in the best interest of SMHS and SMH to consummate the Transaction and to enter into and perform their respective obligations under the Transfer Agreement and the Transaction Documents.

NOW THEREFORE, it is hereby:

RESOLVED: That the Boards believe it to be advisable and in the best interests of SMHS and SMH to consummate the Transaction.

RESOLVED: That SMHS and SMH enter into the Transfer Agreement, in substantially the form presented to the Boards and attached hereto as Exhibit A, and that the President and Chief Executive Officer of SMHS and SMH, respectively (collectively, the "Authorized Officer") be, and hereby is, authorized and directed to negotiate, execute and deliver in the name of SMHS and SMH the Transfer Agreement with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH respectively, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority thereunder; and be it further

RESOLVED: That SMHS and SMH enter into such applications, licenses, registrations, agreements, instruments, documents, and all such other Transaction Documents as such Authorized Officer may deem necessary or advisable to effectuate the Transaction and that such Authorized Officer be, and hereby is, authorized to negotiate, execute and deliver in the name of SMHS and SMH, respectively all such applications, licenses, registrations, agreements, instruments, documents and all such other Transaction Documents with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH, respectively, in connection with obtaining all regulatory approvals, licenses, permits, consents, certificates, determination letters or other authorizations necessary or advisable to consummate the Transaction, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder; and be it further

RESOLVED: That such Authorized Officer be, and hereby is, authorized to complete, execute and deliver in the name of SMHS and SMH, respectively such which such Authorized Officer in his sole discretion deems necessary or appropriate and in the best interests of SMHS and SMH , the execution and delivery of the foregoing to be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder, and be it further

RESOLVED: That the officers of SMHS and SMH be, and each acting singly hereby is, authorized and empowered, in the name and on behalf of SMHS and SMH, to take or cause to be taken any and all actions and to execute and deliver or cause to be executed and delivered any and all agreements, resolutions, documents, certificates, reports and regulatory or other notices or filings, and to incur any and all fees and expenses necessary or appropriate in the opinion of such officer to effect the foregoing resolutions, which action or execution and delivery thereof shall constitute conclusive evidence of the authorization and approval of such action by SMHS and SMH; and be it further

RESOLVED: That all actions heretofore taken by any officer or director of SMHS and SMH in connection with or otherwise in contemplation of the matters contemplated by the foregoing resolutions be, and they hereby are, authorized, approved, ratified and confirmed in all respects.

Saint Mary's
HEALTH SYSTEM

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
Special Boards of Directors Meeting
Thursday, September 17, 2015

Present	Staff Present	Excused
Robert J. Mazaika, Chair	Robert J. Anthony, Esq. (via phone)	Michael O'Brien
Rev. Monsignor James Coleman (via phone)	Ralph Becker	Jim Smith
Eric Albert (via phone)	Victoria Cipriano	
S. Mark Albini, M.D.(via phone)	Steve Schneider, M.D.	
Joseph Carlson (via phone)		
Garrett Casey (via phone)		
Stephen R. Griffin, Esq.		
Robert Gumbardo, M.D. (via phone)		
Michael Karnasiewicz, M.D. (via phone)		
Sister Dolores Lahr, CSJ		
Angela Mattie		
Joseph Mengacci, Esq. (via phone)		
Richard Pugh (via phone)		
Felix Rodriguez (via phone)		
Robert Roscoe (via phone)		
Christine Sullivan, Esq. (via phone)		
James Uberti, M.D.		
Chad W. Wable		

I. **Call to Order & Opening Prayer**
Upon provision of due notice, the meeting of the Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. Boards of Directors was called to order by the Chairman, Robert J. Mazaika, at 7:00 a.m. with the opening prayer offered by Monsignor J. Coleman.

II. **Report of the Chairman**
Report of Board Taskforce
Mr. Mazaika advised that a revised Transfer Agreement and Board Resolutions were available via the SMHS Board Portal. He asked the Board if anyone had any questions or comments.

Action: Motion made and seconded to approve the transfer of SMHS and SMH membership to Trinity Health through the New England Regional Health Ministry and to change our juridical person to Catholic Health Ministries. Attorney Joseph Mengacci opposed the vote.

Mr. Mazaika reminded everyone to keep this information confidential for one more day. A formal signing of the documents will be held tomorrow, Friday, September 18, 2015, and at that time an announcement will be released to the public. Mr. Wable advised that Rick O'Connell, Executive Vice President of the East Group, and Chris Dadlez, Saint Francis Care, will attend the signing at 12 noon in the Auditorium.

Dr. Uberti congratulated and commended the Taskforce members past and present for their many hours of work.

Mr. Wable advised that the CON process is underway and will file legal notice immediately and anticipate filing a complete CON by November 30th.

III. **Announcements/Relevant Readings/Agenda Items**
Mr. Mazaika advised that the next SMHS/SMH Board Meeting will be held on September 24, 2015, Thursday: 7:00 a.m. – 9:00 a.m. in the Archbishop Daniel A. Cronin Boardroom.

IV. **Adjournment**
There being no further business, the meeting adjourned at 7:08 a.m.

Respectfully submitted,

Victoria Cipriano
Recording Secretary

Approved by,

Robert J. Mazaika
Chairman of the Board

EXHIBIT 11

Town	Discharges	% of Total
PLANTSVILLE	42	0.36%
BETHLEHEM	67	0.58%
MORRIS	14	0.12%
THOMASTON	156	1.34%
WATERTOWN	621	5.34%
WOODBURY	126	1.08%
BEACON FALLS	69	0.59%
CHESHIRE	184	1.58%
MIDDLEBURY	176	1.51%
NAUGATUCK	1,068	9.18%
OXFORD	78	0.67%
PROSPECT	389	3.34%
WATERBURY	6,837	58.75%
WOLCOTT	727	6.25%
PLYMOUTH	73	0.63%
SOUTHBURY	242	2.08%
Other	768	6.60%
Total	11,637	100.00%

EXHIBIT 12

STATE OF CONNECTICUT

Department of Public Health

License No. 000055

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Saint Mary's Hospital, Inc., Waterbury, CT, d/b/a **Saint Mary's Hospital, Inc.** is hereby licensed to maintain and operate a General Hospital.

Saint Mary's Hospital, Inc. is located at **56 Franklin Street, Waterbury, CT**

32 Bassinets
347 General Hospital Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2015

Satellites:
Saint Mary's Department of Behavioral Health Care Services, 100 Jefferson Square, Waterbury, CT
Saint Mary's Hospital Urgent Care Center, 799 New Haven Road, Naugatuck, CT 06770
Saint Mary's Urgent Care Center, 503 Wolcott Road, Wolcott, Ct 06716
Naugatuck Valley Surgical Center, 160 Robbins Street, Waterbury, CT 06708
Saint Mary's Hospital Family Health Center, 95 Scovill Street, Waterbury, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

FRANKLIN MEDICAL GROUP, PC
799 NEW HAVEN ROAD
NAUGATUCK, CT 06770

LABORATORY DIRECTOR

PETER JACOBY, MD

CLIA ID NUMBER

07D1020707

EFFECTIVE DATE

12/30/2013

EXPIRATION DATE

12/29/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
Centers for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

79 Certs1 120313

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

07/21/2015 11:42AM (GMT-04:00)

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS	CLIA ID NUMBER
POND PLACE PEDIATRICS 166 WATERBURY RD, SUITE # 202 PROSPECT, CT 06712	07D2043173
LABORATORY DIRECTOR	EFFECTIVE DATE
KAREN ELIZABETH KENNEDY DIR	06/28/2014
	EXPIRATION DATE
	06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

92 Certs1_060314

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CLIA ID Number: 07D2043173
POND PLACE PEDIATRICS
56 FRANKLIN STREET
LAWLOR BLDG, 1 ST FLOOR
WATERBURY, CT 06706

STATE AGENCY ADDRESS AND PHONE NUMBER:

CLIA LAB PROGRAM/DEPT OF PUBLIC HEALTH

410 CAPITOL AVENUE, MS#12-HSR
PO BOX 340308
HARTFORD, CT 06134-0308
(860)509-7400

LABORATORY MAILING ADDRESS:

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

FRANKLIN MECICAL GROUP PC
166 WATERBURY ROAD
PROSPECT, CT 06712

CLIA ID NUMBER
07D1106888

EFFECTIVE DATE
10/23/2013

LABORATORY DIRECTOR
MARIE P LIVIGNI

EXPIRATION DATE
10/22/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

152 Certs_092413

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

WOLCOTT INTERNAL MEDICINE
503 WOLCOTT ROAD
1 ST FLOOR
WOLCOTT, CT 06716

CLIA ID NUMBER

07D2043175

EFFECTIVE DATE

06/28/2014

LABORATORY DIRECTOR

LAURA C BRENES DIRECTOR

EXPIRATION DATE

06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

93 Certs1_060314

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CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS	CLIA ID NUMBER
FRANKLIN FACULTY PRACTICE DBA FRANKLIN MEDICAL GROUP 133 SCOVILL ST, STE 102 WATERBURY, CT 06706	07D1028439
LABORATORY DIRECTOR	**EFFECTIVE DATE**
	07/23/2014
JASON OUELLETTE MD DIRECTO	**EXPIRATION DATE**
	07/22/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

297

103 Certs1_062414

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
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EXHIBIT 13

PROFESSIONAL STATEMENT

A PASSIONATE, CONTEMPORARY AND HIGHLY ACCOUNTABLE LEADER DEDICATED TO BUILDING ESSENTIAL RELATIONSHIPS WITHIN THE MEDICAL COMMUNITY AND BROADER COMMUNITY IN ORDER TO COME TOGETHER AS A TEAM TO TRANSFORM HEALTHCARE INTO A CONSUMER-ORIENTED SYSTEM OF REGIONAL HEALTHCARE SERVICES WITH THE RIGHT PATIENT RECEIVING THE RIGHT CARE IN THE RIGHT LOCATION RESULTING IN A VERY GOOD PATIENT EXPERIENCE THAT IS SUBSTANTIALLY BETTER QUALITY CARE, TRUSTED AND SAFE WHILE DRAMATICALLY REDUCING THE TOTAL COST OF CARE OVER TIME.

EXPERIENCE

Saint Mary's Health System, Inc., Waterbury, CT

Integrated network of healthcare services including Saint Mary's Hospital (347 beds), a Level 2 Trauma Center and NICU, Saint Mary's Hospital Foundation, Saint Mary's Indemnity Company, Naugatuck Valley Surgical Center, Harold Leever Regional Cancer Center, Heart Center of Greater Waterbury, Diagnostic Radiology of Southbury, Naugatuck Valley MRI, and Franklin Medical Group.
STATS: 12,000 admissions, 70,000 ED visits, 18,000 surgeries, 3 residency/teaching programs, $280 million in net revenues, 400 active members of the medical staff and 2,000 staff.

President and Chief Executive Officer (2008-present)

Major Accomplishments:

Growth and Finance

- ✓ One of seven hospitals in CT to achieve a positive five-year average operating margin.
- ✓ Increased DCOH from less than10 days to over 70 days.
- ✓ Lowest cost hospital in CT based on total cost per discharge.
- ✓ Established largest robotic surgery program in the region.
- ✓ Operate the largest freestanding surgical center in CT.
- ✓ Opened first community hospital based open heart and angioplasty program in CT.
- ✓ Aligned three physician groups into one large, integrated 100 provider multi-specialty group.
- ✓ Consolidated pediatric services in Waterbury with Connecticut Children's Medical Center establishing a hospital within a hospital at Saint Mary's Hospital.
- ✓ Established a hospital within a hospital partnership with VITAS for an inpatient hospice.
- ✓ Led the Board through an affiliation process resulting in multiple options for a transaction.
- ✓ Led the establishment of a wholly owned insurance company and risk management program.

Service and Quality

- ✓ Received the national quality performance award by the Joint Commission.
- ✓ One of Ten hospitals nationally selected to receive an ACC Patient Navigator Program Grant.
- ✓ Improved inpatient and ambulatory surgery HCAHPS more than 50 percentile points.
- ✓ Reduced patient falls and hospital acquired infection from over 200 to less than 100.
- ✓ Achieved top decile nationally for over 77% of all reportable CMS Core Measures.
- ✓ Achieved recognition five consecutive years by AHA *Get with the Guidelines* as a Gold Award Hospital for treatment of heart failure, MI and stroke.
- ✓ Achieved Consumer Reports safest hospital in CT 2013 and 2014.
- ✓ Recognized as a Top 100 Community Value Leadership Award Winner by Cleverley and Assoc.

Executive Vice President, Strategy Development and System Operations (2008)

Vice President of Ambulatory Operations and Business Development (2003-2008)

Responsible for strategic management, business development and community relations activities for the Health System. Responsible for all outpatient operations within the Health System with responsibility for growing market share, achieving Balanced Scorecard results and leading change within the organization.

Major Accomplishments:

- ✓ Served as a member of the senior management team responsible for successfully implementing a $24M financial turnaround plan.
- ✓ Led the planning, development and CON process for the establishment of a collaborative open heart and cardiac angioplasty program.
- ✓ Successfully recruited several physicians including several internists, breast surgeons, neurosurgeon, neurologist, cardiologists and a cardiothoracic surgical team.
- ✓ Led the development of a new Stroke Program consistent with the American Stroke Association *Get with the Guidelines* program.
- ✓ Led the development of a Bariatric Surgical Program in pursuit of accommodation as a Center of Excellence by the ASMBS and SRC.
- ✓ Established comprehensive community benefits program.
- ✓ Led the development of a comprehensive women's & breast services strategy including a new breast surgical practice and the development of diagnostic services.
- ✓ Led redesign of ambulatory care delivery system including six new outpatient facilities and enhanced technology resulting in over $1.0 million in annual incremental income.
- ✓ Introduced new patient advocacy program including patient rounding, real-time recovery process and a functional reporting system.
- ✓ Led team responsible for coordinating and developing an affiliation strategy including assessing local consolidation and national partnership options.
- ✓ Led the redesign of a primary care network of hospital sponsored and private practices.
- ✓ Led the establishment of the first freestanding hospital-owned MRI Center in Waterbury.

Corporate Director of Strategic Planning and Business Development (2002-2003)

Responsible for leading the Board and Senior Management through a comprehensive strategic planning process resulting in the first system-wide long range strategic plan including master facility, medical staff development, quality improvement, image improvement, information systems and long range financial plans. Provided management support for marketing, community relations, medical staff development, imaging services, health information management, plant operations and support services. Reported directly to President & CEO.

Major Accomplishments:

- ✓ Lead annual strategic planning process including annual update of a five year strategic plan.
- ✓ Designed and administered a Balanced Scorecard for enhancing relationships, clinical effectiveness and improving operating performance.
- ✓ Led the completion of a comprehensive master facility plan including optimizing the current facility and long term options for rebuilding in place and new construction.
- ✓ Led the completion of the medical staff development plan including a community needs assessment, physician satisfaction survey and the establishment of physician recruiting policies, procedures and strategies.
- ✓ Designed and implemented an image improvement strategy including the redesign of the marketing and community relations functions resulting in dramatically improved brand identity and consumer perception.
- ✓ Led redesign of imaging services including establishment of a new professional services agreement with a local radiology group.
- ✓ Led team responsible for improved charge capture and front-end revenue cycle improvement.

Monongalia Health System, Inc., Morgantown, WV

Integrated network of healthcare services including Mon General Hospital, The Foundation of Mon General Hospital, MonHealthcare Equipment & Supplies, Monongalia EMS, The Village at Heritage Point, Healthworks Rehab & Fitness, Care Partners, HealthSouth Rehab Hospital.

Director of Strategic Planning and Business Development (2000-2002)

Strategic Analyst (1999-2000)

Post-graduate Fellowship, Healthcare Administration (1999)

West Virginia University, Morgantown, WV

Instructor, Community Health Education (1998-1999)

EDUCATION

West Virginia University, Morgantown, WV
Master of Business Administration, August 2002
Master of Science in Community Health Education, December 1999
Master Certificate in Healthcare Administration, December 1999
Bachelor of Science in Biology, May 1998

PROFESSIONAL AFFILIATIONS/CERTIFICATIONS
American College of Healthcare Executives – Fellow
American Hospital Association, Metropolitan Governing Board
Connecticut Hospital Association – Board of Directors
CT Chapter American College of Healthcare Executives – Board of Directors
Certified High Reliability Trainer through HPI
Six Sigma Green Belt with Lean and Workout Training through Juran Institute

COMMUNITY SERVICE
United Way of Greater Waterbury, Board of Directors, Chairman (2010-2012)
Greater Waterbury YMCA, Board of Directors
Waterbury Regional Chamber of Commerce, Board of Directors
Saint Bridget's School, Board of Directors
Rezziliant, Inc., Board of Advisors (2005-2010)
Visiting Nursing Association, Board of Directors (2004-2007)

AWARDS AND HONORS
Connecticut Magazine 40 under 40 Award recipient (2011)
Modern Healthcare Magazine "Up & Comers" Award recipient (2010)
American College of Healthcare Executives, Early Careerist Award, Connecticut Chapter (2006)
West Virginia University, Varsity Football
- Big-East Conference Scholar-Athlete first team (1994-1997)
- Ira E. Rogers Award for high leadership, academic qualities, and football performance (1997)

Ralph W. Becker

255 Hobart St, Southington, CT 06489
rwbecker@cox.net
Cell: 203-537-5412
Home: 860-426-9207

1985 – 2013 Midstate Medical Center, Meriden, Connecticut www.midstatemedical.org
Midstate is a 144 bed hospital with $200 million in annual net revenues.
Midstate is part of the Hartford Healthcare System.

Vice President and CFO
Responsible for all financial reporting, budgeting, financings, managing managed care, revenue integrity / enhancement, physician financial agreements and ventures. Currently oversee Finance, Accounting, Budgeting; have previously overseen Health Information Management (Medical Records), Materials Management, and Service Access. Also, Chair the hospital's Risk Management Committee. Report to the hospital CEO and the CFO for the system.

Significant accomplishments:
Instrumental in maintaining consistently positive operating results in a changing environment for more than a decade. Feasibility analysis, Certificate of need preparation, and financial oversight of a hospital merger, then subsequent construction of a new hospital at a new location. Coordinated feasibility analysis and financings for multiple building programs (most recently a major expansion within the last 4 years). Established and oversee a multi-disciplinary revenue enhancement (revenue cycle) function (for more than a decade). Responsible for achieving very favorable managed care rates and terms; the hospital's "private payment to cost" ratio averages 1.4 (best in Connecticut) for many years. Helped build a positive relationship with our affiliated physicians. Served on the Board of Directors as CFO of the PHO.

1981- 1985 Ernst & Young (formerly Ernst & Whinney) Hartford Connecticut.
Senior Consultant (health care consulting team).
Oversight or involved with various consulting engagements (including reimbursement, cost reporting, revenue enhancement, feasibility studies).

1974- 1981 Anthem Blue Cross (formerly Blue Cross & Blue Shield of Connecticut)
Positions progressing to Senior Reimbursement Analyst / Auditor.
Oversight or involved in Medicare Audit and Reimbursement functions.

Education:
MBA Finance – University of New Haven, New Haven Connecticut
BS in Finance – Norwich University, Northfield Vermont
Community: Served on Executive Committee and Board of Directors of the Quinnipiac Chamber of Commerce (Wallingford and North Haven Connecticut) for 11 years

CHARLES M. FLINN, FACHE

214 West Chestnut Street - Unit 303
Kingston, New York 12401

(Cell) 845-399-5992
Email: chip.flinn@gmail.com

SUMMARY OF EXPERIENCE:

Highly visible, results-oriented health care executive with 16 years in leadership. Effective communicator with strong clinical, quality and fiscal skills, experienced in change management, the ability to align diverse stakeholders, and develop employee, medical staff and board relations. Strategic, quality-focused leader with distinguished performance in process improvement and system integration utilizing Lean and Six Sigma acumen. Proven abilities include programmatic development leading to a national "number one in overall patient satisfaction" award from The Jackson Group (NRC Picker).

PROFESSIONAL EXPERIENCE:

Executive Vice President-COO — **HealthAlliance of the Hudson Valley, Kingston, NY** — **2009-Present**

Executive Vice President of two long-standing, fiercely competitive community hospitals situated less than 1 mile apart. Under Berger Commission edict, initiated strategy and execution of plan to combine into a financially successful integrated healthcare delivery system.

- Set strategies and goals to achieve financial performance targets over two hospitals, all ambulatory, behavioral health, support and emergency services;
- Completed $22.5M in capital projects, including new ORs, ED, clinical consolidations of nursing units;
- Aligned and rebuilt diverse workforce of 2,400 through training in contemporary management to build one seamless organization;
- Development of clinical integration model for 78 primary care physicians striving towards an ACO model;
- Developed physician-centric Centers of Excellence in Breast Health, Ortho & Vascular Surgery;
- Combined two emergency departments into one 50,000 visit department and accomplished a positive $2M revenue enhancement project while improving organizational throughput;
- Negotiated new annual contracts with EM Group, Radiologists and EMS provider through RFP processes;
- Restructured physician practice model from employed model to private office practice at the critical access hospital – decreased expenses in excess of $320,000;
- Completely re-engineered care delivery model for behavioral health service line turning around a deficit to a $1.2M favorable contribution margin while improving patient outcomes significantly;
- Re-designed, raised funding for and construction of $1.6M oncology infusion, breast health and pre-surgical centers; and
- Awarded HealthGrades Top 5% award for Patient Safety.

Vice Chair, Operating Committee — **Hudson Health Partners, Newburgh, New York** — **2011-Present**

Established in 2012, Hudson Health Partners is a controlled for-profit joint venture corporation linking four Hudson Valley hospital systems into a single, non-asset merged healthcare corporation focused on employee self-insurance, physician centric care management improvements and continuum of care coordination pre- and post hospital. Through contiguous geographic scale, HHP serves Orange, Rockland, Dutchess and Ulster counties, encompassing a scope of 1.1 M in population, 1,200 physicians and collective operating budgets of over $1 billion.

- Quality initiatives and best practices to ensure that residents of the region have access to exceptional care;
- Clinical collaborations including population health and wellness initiatives to enhancement and expansion of care delivery throughout the region;
- Physician Services including recruitment, medical education, Electronic Health Records, and practice management services.
- Hospital services, pilot projects/incubators, clinical care paths and shared support services.
- Enhanced efficiencies gained through population management, group purchasing and sharing of resources to reduce costs.

Vice President-Chief Administrative Officer **Saint Clare's Health System, Denville, NJ** **2005-2009**

Vice President of $300M, multi-campus healthcare system serving a community population exceeding 300,000 in northwest New Jersey. Total 500 licensed beds with direct operational oversight of Nursing (Med/Surg, ED, ICU, OR, L&D, PACU, Oncology, Cardiac Cath and Peripheral labs), Laboratory, Radiology, Cardiology, Respiratory, Endoscopy, Women's Health, Emergency Medical Services and Support Services. Service Line Executive and Champion for Women's Health, Minimally Invasive Orthopedic and Robotic Surgery, Cardiac and Vascular Programs and Inpatient/Outpatient imaging

- Developed of tri-annual strategic plans, including joint ventures with cardiology and vascular surgeons;
- Launch of the Miracles Campaign - a community philanthropic initiative to raise $200M from community, employees and medical staff;
- Constructed $11M mother/child center - the Katena Center - on-time and under budget;
- Partnered with physicians to design and develop a pediatric neuro-epilepsy program and inpatient unit;
- Increased market share of emergency medical services by more than 16% over two-year period;
- Led community and state approvals (DOH, DEP, DEC) for $75MM patient access/parking structure
- Achieved approval for State primary stroke center designation;
- Led organization from concept through completion of $3.8MM interventional labs;
- Improvement of radiology cycle and waiting times by 37% reduction, utilizing Lean Six Sigma methods;
- Opened an Outpatient Imaging Center, $1.9M on-time and on-budget;
- Aggressive efforts to develop a "high-technology/high-touch" culture;
- Planned the region's first 30-minute *'Door to Doctor'* program in the Emergency Department;
- Enhanced medical staff relations (~748 credentialed staff), fostering relationships to partner with administration;
- Purchased and implemented a daVinci Robot for minimally invasive urologic and gynecologic surgery;
- Improved oncology program with enhanced care delivery utilizing Tomo-Therapy radiation in new center of excellence - Cancer Care at Saint Clares;
- Improved financial performance with developed financial dashboards; demonstrated 37% performance increase.

Director, Emergency Services **St, Joseph's Mercy of Macomb Hospital, Clinton Township, Michigan** **2004-2005**

Responsible for daily business operations of Emergency Department with $9M annual budget, 54,000 annual visits, 10,000 of which resulted in admissions. Developed strong leadership of nursing and physicians and liaison with all clinical and non-clinical departments. Managed 30-minute guarantee for patients - 97% efficiency; leading to 85th percentile NRC patient satisfaction.

Executive Director-Patient Access **University of Medicine & Dentistry of New Jersey, Newark, New Jersey** **2002-2004**

Responsible for daily business operations of Emergency Department with $19 Million annual budget, 76,000 ED visits, 13,000 admissions for a 430 bed academic hospital, ACS Accredited Level I Trauma Center. Executive oversight of bed control, out-patient registration and admitting – Matrix Reporting structure.

- Awarded "Runner-Up" for best performance improvement project FY03;
- *"Decreasing Medical Screening Exam-A Pilot Study"* - July 2002;
- Nominated for Modern Healthcare's *"Up and Comer Award"* for significant achievement in healthcare;
- Reduced "missing charts" from ~120/month to <5/month in Q1 FY04 through rapid design process improvement;
- Identified root-causes of unbilled revenue of the outpatient revenue;
- Administrative Champion for MedAptus physician (professional) billing software via "palm" device and wireless network;
- Developed and implemented "balanced scorecard" for performance improvement metrics; and
- Completed design and construction of $14 million renovation of emergency department.

CFO–Department of Surgery **University of Medicine & Dentistry of New Jersey, Newark, NJ** **2002-2004**
Administrative Director **Good Samaritan Hospital Medical Center, West Islip, New York** **1998-2002**

EDUCATION:

Dowling College, Oakdale, New York, Master of Business Administration-Management	2002
St. Joseph's College, Patchogue, New York, Bachelor of Science-Healthcare Administration	2000

PROFESSIONAL AND BOARD MEMBERSHIPS:

American College of Healthcare Executives (ACHE), Fellow	2007
HANYS Chief Operating Officers Committee	2009
NORMET Patient Safety Organization	2010

CHRISTOPHER M. DADLEZ, FACHE

HOME:
9 Cobtail Way
Simsbury, CT 06070
(860) 2167-1648
CDadlez@aol.com

OFFICE:
Saint Francis Hospital and Medical Center
114 Woodland Street, Hartford, CT 06105
(860) 714-5541 Fax (860) 714-7920
CDadlez@stfranciscare.org

SUMMARY

A healthcare career of 30 years successfully leading and managing large, complex organizations.

PROFESSIONAL EXPERIENCE

PRESIDENT AND CHIEF EXECUTIVE OFFICER
Saint Francis *Care*, Inc.
Saint Francis Hospital and Medical Center
(2004 to present)

Saint Francis Hospital and Medical Center has been an anchor institution in North Central Connecticut since its founding in 1897 by the Sisters of Saint Joseph. Licensed for 617 beds, it is one of the largest hospitals in Connecticut and is the largest Catholic hospital in New England. We are a multidisciplinary, leading-edge teaching hospital.

Saint Francis affiliated with Mount Sinai Hospital in 1990 to create a new regional healthcare system. This was the first recorded instance of a merger between a Catholic hospital and a Jewish hospital in United States history. In October 1995, the two institutions completed a formal corporate merger.

A regional referral center, Saint Francis provides sophisticated, contemporary medicine with major clinical concentrations in cardiology, orthopedics, oncology, orthopedics, women's services and rehabilitation. The achievement of excellence is emphasized through centers of excellence, which focus on quality, caring and the dignity of every patient.

Saint Francis has been named a Solucient "Top 100 Hospital" seven times, a "Top 100 Cardiac Program" three times, and a "Top 100 Performance Improvement Hospital" twice. It is also the recipient of the Leapfrog Top 50 Hospitals award and has been recognized by Care Science Top 1% of all hospitals in clinical outcomes.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
CSAHS/UHHS-Canton, Inc.
Mercy Medical Center
(2000-2003)
CSAHS/UHHS, Inc. is the not-for-profit Partnership representing the Sisters of Charity of St. Augustine Health System (CSAHS) and University Hospitals Health System (UHHS) of Cleveland. The Partnership operates Mercy Medical Center in Canton, Ohio and its regional health centers in North Canton, Carrollton, Jackson Township, Louisville, and Dover, Ohio

Responsible for efficient and effective operation and strategic direction of the organization reporting directly to the Partnership Board.

Mercy Medical Center was named a "Top 100 Hospital" for 2001 and 2002, Top 100 Cardiovascular Services Hospital for 2001 and 2002 and a Top 50 U.S. News & World Report Best Hospital for cardiovascular services for 2001 and 2002. In 2001 Mercy received the prestigious AHA Nova Award for innovative community outreach programs. For the last three years Mercy has attained record numbers in admissions, outpatient visits, net revenue and productivity.

CHRISTOPHER M. DADLEZ, FACHE

EXECUTIVE VICE PRESIDENT
Saint Barnabas Health Care System
(1996 to 2000)
Parent company of the largest healthcare provider in New Jersey. This 2 billion-dollar annual revenue company consists of ten acute-care hospitals, one children's hospital, 48 ambulatory centers, 23,000 employees, 4,000 physicians and 450 medical residents.

Member of the Office of the President/Executive Management Committee. Responsible for the strategic direction and centralized management of this dynamic organization. System-wide responsibilities include all clinical integration, development of center(s) of excellence, product line operations, marketing and development, and graduate medical education.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
MID-ATLANTIC HEALTH GROUP
Parent company of Monmouth Medical Center. Monmouth Health Care foundation: Mid-Atlantic Health Care: Monmouth Chemical Dependency Treatment Center, MA Resources and Monmouth Medical Surgi Center, Inc. Merged this holding company with two other organizations to form the new Saint Barnabas Health Care System.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
MONMOUTH MEDICAL CENTER
(1992-1996)
Responsible for the efficient and effective operation and strategic direction for this 526-bed community teaching hospital (with 2,000 FTEs and an operating budget of $170 million). Affiliated with the Medical College of Pennsylvania and Hahnemann University

EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER
SINAI HOSPITAL BALTIMORE, MD
(1986-1992)
EXECUTIVE VICE PRESIDENT

SINAI HEALTH SERVICES
(1986-1992)
VICE PRESIDENT
(1984-1986)
Responsible for the day-to-day operation of this 467-bed teaching hospital and medical center. Affiliated with the Johns Hopkins Medical School and with an operating budget exceeding $190 million and 2,700 FTEs. All aspects of this organization reported to the COO with the exception of Finance. Advised the President on operational and strategic policy. Member of Medical Staff and Board Executive Committees. Served as Chief Operating Officer of holding company, which had responsibility for all hospital-affiliated corporations. Acted as CEO during absence of President.

ASSISTANT ADMINISTRATOR
GREATER LAUREL BELTSVILLE HOSPITAL
LAUREL, MD
(1981-1984)
Assistant Administrator of 236-bed acute-care facility which was part of a 900-bed multi-unit system.

ASSISTANT ADMINISTRATOR
WAYNESBORO HOSPITAL
WAYNESBORO, PA.
(1979-1981)
Acting CEO from 1979 to 1980 while recruiting permanent CEO. Responsible for managing all operations of the hospital

ADMINISTRATIVE FELLOW – 4/79-12/79
ADMINISTRATIVE RESIDENT – 8/78-7/79
EVENING ADMINISTRATOR – 7/77-8/78
RICHMOND MEMORIAL HOSPITAL
RICHMOND, VA.

CHRISTOPHER M. DADLEZ, FACHE

EDUCATION

Loyola College, Baltimore, MD
Advanced Graduate Course in Business and Finance
Medical College of Virginia, Virginia Commonwealth University
Richmond, VA Masters in Hospital Administration 1979
University of New Hampshire, Durham NH
Bachelor of Arts, Biology 1975

MEMBERSHIPS & APPOINTMENTS

Alliance of Independent Academic Medical Centers (AIAMC)
Board of Directors and Executive Committee – 2005 to present
American College of Healthcare Executives (ACHE) – Fellow – 1990 to present
American Hospital Association Regional Policy Board – Alternate Delegate and Delegate – 2007 to present
American Hospital Association Equity of Care Committee – 2011
American Hospital Association Fellow in Healthcare Reform - 2011
Association of American Medical Colleges (AAMC) – Member – 1984 to present
Business Hall of Fame – 2011
Council of Teaching Hospitals and Health Systems (COTH) – Member – 1984 to present
Council for Accreditation of Health Management Education – Surveyor – 2006 to present
Catholic Health Association (CHA) – Member – 2000 to present
Connecticut Hospital Association – Board of Directors – 2006 to present
Chairman, Board of Directors – 2010 to present
Vice Chairman, Board of Directors – 2008 to 2010
Chairman, Finance Committee – 2006 to present
Capital Area Health Consortium – Member – 2004 to present
Connecticut Catholic Hospital Council – Member – 2004 to present
Connecticut Catholic Conference – Member – 2004 to present
Governor's Task Force on Hospital Reform – Member – June to December 2007
Governor's Connecticut Healthcare Reform Advisory Board – 2009-2010
Medical College of Virginia, Department of Healthcare Administration
Alumni Executive Committee and Past President
Adjunct Faculty/Lecturer/Preceptor

Ohio Hospital Association
Research & Education Foundation Board of Directors 2001 to 2003
Committee on Workforce Crisis Board of Directors 2001 to 2003
Akron Regional Hospital Assoc. Board of Directors 2003
University Hospitals Regional Network Board of Directors 2000 to 2003
Premier Health Alliance – Chicago, IL – Board of Trustees and various committees (1993 to 1996)
New Jersey Hospital Association (1993 to 2000)
NJHA – Treasurer
NJHA – Chairman, Finance Committee
NJHA – Investment Committee
NJHA – Chairman of the Political Action Committee
NJHA – Member of the Board of Trustees/Executive Committee
NJHA – Member of Health, Research and Educational Trust of New Jersey – Board of Directors
NJHA – Member for Center for Health Affairs Board
NJHA – Past Chairman, Integrated Delivery System Committee
NJHA – Past Chairman, Committee on Managed Care
NJHA – Member of Visioning and Strategic Planning Committee
NJHA – Member of Select Committee for Development of New Payment System
NJHA – Member of Membership Committee
NJHA – Member of Executive Compensation Committee
New Jersey Joint Teaching Hospital Forum
First Option Health Plan of New Jersey, Founder/Board of Trustees/Executive Committee
Council of Teaching Hospitals – Delegate to American Association of Medical Colleges

CHRISTOPHER M. DADLEZ, FACHE

American Hospital Association – Political Action Delegate
Johns Hopkins University, Department of Healthcare Administration
Adjunct Faculty/Lecturer/Preceptor

ITEMS OF NOTE

Served as faculty member and speaker at many national healthcare conferences and have appeared on television and radio programs to discuss all aspects of the healthcare field. In 1992 received the CAPE award for the finest healthcare program aired on cable television in New Jersey.

CONNECTICUT COMMUNITY SERVICE

Governor's Council on Economic Competitiveness and Technology	Member	2006 to present
MetroHartford Alliance	Board of Directors	
Diversity and Inclusion Committee	Chairman	2005 to present
Malta House of Care	Board of Directors	2006 to present
Mayor's Healthy Communities Initiative	Member	2005 to present
Committee to End Chronic Homelessness	Member	2005 to 2006
Greater Hartford Arts Council	Member	2006 to present
Bushnell Ovations Committee	Member	2005 to 2006

OHIO COMMUNITY SERVICE

United Way	Board of Directors	2001 to 2004
Catholic Charities	Board of Directors	2001 to 2004
Walsh University	Board of Directors	2001 to 2004
Boy Scouts of America	Board of Directors	2001 to 2004
Canton Central Catholic High School	Board of Directors	2001 to 2004
YMCA	Board of Directors	2001 to 2004
Stark County Development Board	Board of Directors	2001 to 2004

PRIOR COMMUNITY SERVICE

Asbury Park Soup Kitchen
American Cancer Society
American Heart Association – 1995 Service Award
Catholic Charities
Founder and Chairman, Long Branch Tomorrow
Ronald McDonald House – Board of Trustees
Monmouth Chemical Dependency Center – Board of Trustees
Long Branch Chamber of Commerce – Board of Directors
Children's Psychiatric Center
Girl Scouts – Monmouth Council
Juvenile Diabetes Foundation – Chaired 1996 "Walk for the Cure"
Honored as Long Branch "Man of the Year 1994"
March of Dimes – Chaired "Walk America"
Monmouth University
United Cerebral Palsy – 1995 Service Award
Honored in 1996 by the Urban League with the Founder's Award

PERSONAL

Born June 16, 1953
Married 34 years to Eileen
Children: Nina age 26 Greg age 24

HOBBIES

Tennis, running, soccer, reading, French

Curriculum Vitae

Name	John F. Rodis, M.D.
Date of Birth	December 27, 1955
Place of Birth	Brooklyn, New York
Home Address	46 Dorset Lane Farmington, Connecticut 06032-2330
Office Address	Saint Francis Hospital and Medical Center Department of Obstetrics and Gynecology 114 Woodland Street Hartford, Connecticut 06105
Telephone	Office: (860) 714-4457 Home: (860) 678-1218
Martial status	Marytherese Conway - October 2, 1987
Children	Alexandra - September 8, 1989 Katrina - May 7, 1992 Anna - May 22, 1995

Education

1972-1976	BA- Biology Cornell University Ithaca, New York
1976-1980	MD Autonomous University of Guadalajara Guadalajara, Mexico
1980-1981	Fifth Pathway St. Joseph's Hospital & Medical Center Paterson, New Jersey
1981-1985	Resident, Obstetrics and Gynecology St. Joseph's Hospital & Medical Center Paterson, New Jersey
1985-1987	Fellowship in Maternal-Fetal Medicine University of Connecticut Health Center Farmington, Connecticut

	1993-1996	Fellowship in Human Genetics Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
	2005	Six Sigma Green Belt Certification
	2007	American College of Physician Executives PIM Course
Licensure	New Jersey Connecticut New York	40792 26709 158721
Boards	1989	Board Certified, American Board of Obstetrics and Gynecology
	1990	Sub-Specialty Certification, Certified by the Division of Maternal-Fetal Medicine, American Board of Obstetrics and Gynecology
	1998	Passed Recertification Examination in Obstetrics and Gynecology and Maternal-Fetal Medicine
Appointments	1985-1987	Instructor, Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
	1987-1993	Assistant Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
	1987-1995	Assistant Professor, Department of Pediatrics School of Medicine, University of Connecticut Health Center Farmington, Connecticut
	1987 - 2001	Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine St. Francis Hospital & Medical Center Hartford, Connecticut

1987 - 2001	Associate Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine New Britain General Hospital New Britain, Connecticut
1991-1993	Residency Coordinator Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Residency Program Director Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Associate Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
1995 – 6/01	Associate Professor, Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
1/99 – 6/01	Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
7/01-3/04	Chairman, Obstetrics and Gynecology Stamford Hospital Stamford, Connecticut
9/01-5/13	Professor of Clinical Obstetrics and Gynecology Columbia University College of Physicians and Surgeons New York, New York
7/11-present	Chair, Department of Obstetrics and Gynecology Director, Women & Children's Health Services Saint Francis Hospital and Medical Center Hartford, Connecticut

2/13-Present	Saint Francis Faculty Fellow Saint Francis Hospital Education Council Hartford, Connecticut
5/13-present	Professor, Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut

Awards

1993	APGO Excellence in Teaching Award, sponsored by APGO Medical Education Foundation
1998	CREOG National Faculty Teaching Award, sponsored by CREOG
2001	CREOG National Faculty Teaching Award, sponsored by CREOG

Societies

Fellow, American College of Obstetrics and Gynecology
Member, Society for Maternal-Fetal Medicine
Connecticut Perinatal Association
Member, American Institution of Ultrasound in Medicine
International Society of Perinatal Obstetricians
Associate Member, Society of Gynecologic Investigation
New England Perinatal Society - Secretary - 1996-1997
New England Perinatal Society - Vice President 1997-1998
New England Perinatal Society - President 1998-1999
Association of Professors in Gynecology and Obstetrics
Hartford County Medical Association
Connecticut State Medical Society
American College of Physician Executives

Committee Appointments

John Dempsey Hospital/University of Connecticut School of Medicine

1986-88	Transfusion Committee
1987-90	John Dempsey Hospital Quality Assurance/Peer Review Committee
1987-90	Chairman, Obstetrics and Gynecology Quality Assurance/Peer Review
1990-2001	Transfusion Committee
1996-2001	Clinical Practice Subcommittee of the Clinical Governance Committee
1996	Clinical Research Task Force
1995-2001	Committee for Graduate Medical Education
1997-2001	Chairman, Operations Subcommittee of Committee for Graduate Medical Education
1998	Search Committee for OB/GYN Chair
1990-2001	Chairman, CADCARS Review Committee Others
1999-2001	Chairman, Committee on Graduate Medical Education
2002-2004	At-large Member, Medical Board

Stamford Hospital Committees/Positions

2002-2004	Chair, Department of Obstetrics and Gynecology
7/01/03- 2011	Senior Vice President Medical Affairs, Chief Medical Officer
2001-2003	Blood Bank Committee
2001-2011	Patient Safety Committee
2001-2011	OR Committee
2002-2011	Credentials Committee
2003-2011	Strategy and Market Development Committee (Board Committee)
2003-2011	Medical Executive Committee
2003-2011	Bylaws Committee
2003-2011	Clinical Leadership Council
2003-2011	Quality and Clinical Affairs Committee (Board Committee)
2003-2011	Ops Council
2003	Chair- Credentials Task Force
2003	Chair, Ob/Gyn Chair Search Committee
2004	Chair, Surgery Chair Search Committee
2004	Emergency Department Chair Search Committee
2002-2004	Medical Board
2005	Chair, Pathology Chair Search Committee
2006	Co-Chair, Radiology Chair Search Committee

Saint Francis Hospital and Medical Center Committees/Positions

2011–present	Chair, Department of Obstetrics and Gynecology
2011-present	Director, Women & Infants Health Services
2011-present	Co-chair, Women & Infants Quality and Practice Council
2011-present	Medical Staff Quality Committee
2011-present	St. Francis Medical Group Board of Directors
2011-present	Chiefs' Forum
2011-present	Capitol Budget Committee
2011-present	IT Executive Steering Committee
2011–present	Surgical Service Performance Improvement Committee
2011-present	OR Steering Committee
2012-present	Quality & Patient Safety

Others (State and National Ob/Gyn Educational Organizations)

1989-1995	Connecticut Hospital Association Committee on Quality Assessment, Chairman, Panel on Obstetrics
1995-2011	Committee on Quality Assessment, Connecticut Hospital Association
1998 -2001	Alternate Program Director Representative for Region I - Council on Resident Education in Obstetrics & Gynecology
1999-present	American Board of Obstetrics and Gynecology Oral Board Examiner
2009-2011	Chair, Chief Medical Officer Group, New York-Presbyterian Healthcare System

Editorial consultation	American Journal of Obstetrics and Gynecology Obstetrics and Gynecology Journal of Clinical Ultrasound American Journal of Perinatology Journal of Maternal-Fetal Medicine Connecticut Medicine- Associate Editor

Grants/Clinical Trials:
NIH grant 1991, "Study of CF carrier screening in primary care settings", Robert M. Greenstein (Principal investigator), John F. Rodis, MD, (Co-Principal Investigator)

CT Research Foundation 1988, "Role of Chlamydia and mycoplasma in villus sampling", John F. Rodis, MD, (Principal investigator)

Adolor Corporation Protocol 14CL306: A Multicenter Phase III, Double-Blind, Placebo-Controlled, Study of ADL8-2698 in Opioid-Induced Postoperative Bowel dysfunction/Postoperative Ileus in Subjects Undergoing Total Abdominal hysterectomy (Principal Investigator)

Publications

1. Cusick W, Leuci D, Viscarello RR, Rodis JF. Anaphylactoid syndrome of pregnancy after intracervical dinoprostone for cervical ripening: a report of 3 cases. J Reprod Med 50:225-228, 2005

2. Cusick W, Provenzano J, Sullivan CA, Gallousis FM, Rodis JF. Fetal nasal bone length in euploid and aneuploid fetuses between 11 and 20 weeks' gestation: a prospective study. J Ultrasound Med 23:1327-1333, 2004

3. Feldman DM, Borgida AF, Rodis JF, Leo MV, Campbell. A randomized comparison of two regimens of misoprostol for second-trimester pregnancy termination. Am J Obstet Gynecol 189:710-713, 2003

4. Cusick W, Stewart J, Parry M, McLoed G, Rakos G, Sullivan C, Rodis J. State mandated prenatal human immunodeficiency virus screening at a large community hospital. Conn Med 67:7-10, 2003

5. Egan JF, Rodis JF, Benn PA. Ultrasound markers of Fetal Down Syndrome. JAMA 285:2856-2857, 2001

6. Feldman DM, Borgida AF, Trymbulak WP, Sanders MM, Barsoom MJ, Rodis JF. Clinical implications of velementous cord insertion in triplet gestations. Am J Obstet Gynecol 184:809-811, 2002

7. Benn PA, Gainey A, Ingardia CJ, Rodis JF, Egan JFX. Second trimester maternal serum analytes in triploid pregnancies: correlation with phenotype and sex chromosome complement. Prenatal Genetics 21:680-686, 2001

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX. Outcomes of pregnancies complicated by ruptured membranes after genetic amniocentesis. Am J Obstet Gynecol 183:937-939, 2000

9. Feldman DM, Borgida AF, Rodis JF, Campbell WA: Irreversible maternal brain injury during pregnancy: a case report and review of the literature. Obstet Gynecol Survey 55:708-714, 2000

10. Barsoom MJ, Prabulos AM, Rodis JF, Turner GW: Vanishing gastroschisis and short bowel syndrome. Obstet Gynecol 96:818-819, 2000

11. Ling PY, Leo MV, Turner G, Rodis JF, Campbell WA. Amnioreduction in triplet fetofetal transfusion. Obstet Gynecol 96:843, 2000

12. Egan JFX, Benn, PA, Borgida AF, Rodis, JF, Campbell WA, Vintzileos AM: Efficacy of screening for fetal Down syndrome in the U.S. from 1974 to 1997. Obstet Gynecol 96:979-985, 2000

13. Benn PA, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. J Matern Fetal Med 9:165-169, 2000

14. Benn PA, Rodis JF, Beazoglou T. Cost-effectiveness of estimating gestational age by ultrasound in Down syndrome. Obstet Gynecol 94:29-33, 1999

15. Benn PA, Leo MV, Rodis JF, Beazoglou T, Collin R, Horne D. Maternal serum screening for fetal trisomy 18: a comparison of fixed cut-off patient specific risk protocols. Obstet Gynecol 93:707-711, 1999

16. Rodis JF. Parvovirus infection. Clin Obstet Gynecol 42:107-120, 1999

17. Rodis JF, Arky L, Egan JFX, Borgida AF, Leo, MV, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Am J Obstet Gynecol 181:1128-1132, 1999

18. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus nonrotational forceps: maternal and neonatal outcomes. Am J Obstet Gynecol 181:1185-1187, 1999

19. Odibo AO, Rodis JF, Sanders M, Borgida AF, Wilson M, Campbell WA. The relationship of amniotic fluid markers of intraamniotic infection with histopathology in cases of preterm labor. J Perinatol 19:407-412, 1999

20. Leo MV, Odibo A, Ling PY, Rodis JF, Borgida A, Campbell W. Transverse arrest: a review of outcomes of rotational forceps and cesarean delivery at a single center. Prim. Care Update Ob Gyns. 5:186, 1998

21. Smulian JC, Egan JF, Rodis JF. Fetal hydrops in the first trimester associated with maternal parvovirus infection. J Clin Ultrasound 26:314-316,1998

22. Odibo AO, Campbell WA, Feldman D, Leo MV, Borgida AF, Rodis JF: Resolution of human parvovirus-induced hydrops after intrauterine transfusion. J Ultrasound Med 17:547-550,1998

23. Feldman DM, Odibo AO, Campbell WA, Rodis JF: Iatrogenic monoamniotic twins as a complication of therapeutic amniocentesis. Obstet Gynecol 91:815-816, 1998

24. Rodis JF, Borgida AF, Wilson M, Egan JFX, Leo MV, Odibo AO, Campbell WA. Management of parvovirus infection in pregnancy and outcomes of hydrops: A survey of the Society of Perinatal Obstetricians members. Am J Obstet Gynecol 179:985-988,1998

25. Rodis JF, Rodner C, Hansen A, Borgida A, Spivey G, Rosengren S. Long-term outcome of children following maternal human B19 parvovirus infection. Obstet Gynecol 91:125-128, 1998

26. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation between umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1. J Matern Fetal Med 6:67-70, 1997

27. Oncken CA, Hardardottir H, Hatsukami DK, Lupo VR, Rodis JF, and Smeltzer JS. Effects of transdermal nicotine or smoking on nicotine concentrations and maternal-fetal hemodynamics. Obstet Gynecol 90:569-574, 1997

28. Odibo, AO, Turner GW, Borgida AF, Rodis JF, Campbell WA: Late prenatal ultrasound features of hydrometrocolpos secondary to cloacal anomaly: case reports and review of the literature. Ultrasound Obstet Gynecol. 9:419-421, 1997

29. Benn PA, Borgida AF, Horne D, Briganti S, Collins R, Rodis JF. Down syndrome and neural tube defect screening: The value of using gestational age by ultrasonography. Am J Obstet Gynecol 176:1056-1061, 1997

30. Gottschall D, Borgida AF, Mihalek JJ, Sauer F, Rodis JF. A randomized clinical trial comparing prostaglandin E2 gel for preinduction cervical ripening. Am J Obstet Gynecol 177:1067-1070, 1997

31. Prabulos AM, Chen H, Rodis JF, Ruby S, Campbell WA. Angiographic embolization of a ruptured renal artery aneurysm during pregnancy. Obstet Gynecol 90:663-665, 1997

32. Rodis JF, McIlveen P, Egan JFX, Borgida AF, Turner GW, Campbell WA. Monoamniotic twins: improved perinatal survival with accurate prenatal diagnosis and antenatal fetal surveillance. Am J Obstet Gynecol 177:1046-1049, 1997

33. Smulian JC, Vintzileos AM, Rodis JF, Campbell WA: Community-based obstetrical ultrasound reports - documentation of compliance with suggested minimum standards. J Clin Ultrasound 24:123-127, 1996

34. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for trisomy 21 in the second trimester fetuses. Obstet Gynecol 89:734-737, 1997

35. Smulian JC, Bhandari, V, Campbell WA, Rodis JF, Vintzileos AM: Value of umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1 as predictors of neonatal hematologic indices and suspected early sepsis. J Matern Fetal Med. 6:254-259, 1997

36. Vintzileos AM, Campbell WA, Rodis JF, Guzman ER, Smulian JC, Knuppel, RA: The use of second trimester genetic sonogram in guiding clinical management of patients at increased risk for fetal trisomy 21. Obstet Gynecol 87:948-952, 1996

37. Vintzileos AM, Egan JFX, Smulian JC, Campbell WA, Guzman ER, Rodis JF: Adjusting the risk for trisomy 21 by a simple ultrasound method using fetal long bone biometry. Obstet Gynecol 87:953-958, 1996

38. Lefcourt LA, Rodis JF: Obstructive sleep apnea in pregnancy. Obstet Gynecol Surv 51:503-506, 1996

39. Benn PA, Horne D, Briganti S, Rodis JF: Elevated second trimester maternal serum hCG alone or in combination with elevated alpha fetoprotein. Obstet Gynecol 87:217-222, 1996

40. Bork MD, Smeltzer JS, Egan JFX, Rodis JF, DiMario FJ, Campbell WA: Prenatal diagnosis of intracranial lipoma associated with agenesis of the corpus callosum. Obstet Gynecol 87:845-848, 1996

41. Hardardottir H, Kelly K, Bork MD, Cusick W, Campbell WA, Rodis JF: Atypical presentation of preeclampsia in high-order multifetal gestations. Obstet Gynecol 87:370-374, 1996

42. Cusick W, Rodis JF, Vintzileos AM, Albini SM, McMahon M, Campbell WA: Predicting pregnancy outcome from the degree of maternal serum alpha fetoprotein elevation. J Reprod Med 41:327-332, 1996

43. Cusick W, Bork MD, Fabbri EL, Benn P, Rodis JF, Buttino L Jr: Trisomy 16 fetus surviving into the second trimester. Prenatal Diag 15:1078-1081, 1995

44. Smulian JC, Campbell WA, Rodis JF, Feeney L, Fabbri EL, Vintzileos AM: Gender-specific second- trimester biometry. Am J Obstet Gynecol 173:1195-1201, 1995

45. Cusick W, Salafia CM, Ernst L, Rodis JF, Campbell WA, Vintzileos AM: Low dose aspirin therapy and placental pathology in women with poor prior pregnancy outcomes. Am J Reprod Immunol 34:141-147, 1995

46. Smulian J, Vintzileos AM, Ciarleglio L, Rodis JF, Campbell WA: Gender-specific patterns of second trimester femur and humerus measurements in fetuses with Down Syndrome. J Mat Fetal Med 4:225-230, 1995

47. Borgida AF, Rodis JF, Hanlon W, Craffey A, Ciarleglio L, Campbell WA: Second- trimester abortion by intramuscular 15-methyl-prostaglandin F_{2alpha} or intravaginal prostaglandin E_2 suppositories: A randomized trial. Obstet Gynecol 85:697-700, 1995

48. Cusick W, Bork MD, Bourque MD, Egan JFX, Rodis JF, Campbell WA: Congenital (Paraesophageal) Hiatal Hernia. The Fetus 4(3):1-5, 1994

49. Smulian JC, Rodis JF, Campbell WA, Grant-Kels JM, Vintzileos AM: Non-oral pyogenic granuloma in pregnancy: a report of two cases. Obstet Gynecol 84:672-674, 1994

50. Campbell WA, Vintzileos AM, Rodis JF, Ciarleglio L, Craffrey A: Efficacy of the biparietal diameter/femur length ratio detect Down syndrome in patients with an abnormal biochemical screen. Fetal Diagn Ther 9:175-182, 1994

51. Cusick W, Vintzileos AM, Rodis JF: The use of second trimester fetal growth curves in predicting intrauterine growth retardation in cases of unexplained maternal serum alpha fetoprotein elevations. J Mat Fetal Med 3:203-207, 1994

52. Lettieri L, Rodis JF, McLean DA, Campbell WA, Vintzileos AM: Incarceration of the gravid uterus. Obstet Gynecol Survey 49:642-646, 1994

53. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. Am J Obstet Gynecol 170:1131-5, 1994

54. Vintzileos AM, Lettieri L , Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. J Mat Fetal Med 3:64-68, 1994

55. Campbell WA, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, Nardi DA: Use of the transverse cerebellar/abdominal circumference ratio in pregnancies at risk for intrauterine growth retardation. J Clin Ultrasound 22:497-502, 1994

56. Egan JFX, Petrikovsky BM, Vintzileos AM, Rodis JF, Campbell WA: Combined pentalogy of Cantrell and sirenomelia - a common etiology? Am J Perinatol 10(4):327-329, 1993

57. Smulian JC, Bandari V, Rodis JF, Egan JFX, Bosse KK, Campbell WA, Vintzileos AM: Fetal inferior vena cava thrombosis: A case report. The Fetus 3(6):7-11, 1993

58. Smulian JC, Rodis JF, Campbell WA, Vintzileos AM: Antenatal diagnosis of severe penile hypospadias. The Fetus 3(4)5-10, 1993

59. Lettieri, L, Vintzileos AM, Rodis JF, Albini SM, Salafia CM: Does "idiopathic" preterm labor resulting in preterm birth exist? Am J Obstet Gynecol 168;1480-1485, 1993

60. Campbell WA, Yamase HT, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique development. Fetal Diagn Ther 8:135-143, 1993

61. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Salafia CM, Pezzullo JC: Do survival and morbidity of the very low birthweight infant vary according to the primary pregnancy complication resulting in preterm delivery? Am J Obstet Gynecol 169:1233-1239, 1993

62. Lettieri L, Rodis JF, Vintzileos AM, Feeney L, Ciagleglio L, Craffey A: Ear length in second trimester aneuploid fetuses. Obstet Gynecol 81:57-60, 1993

63. Benn P, Ciarleglio L, Lettieri L, Rodis J, Greenstein R: A rapid (but wrong) prenatal diagnosis (letter). N Engl J Med 326:1638-40,1992

64. Lettieri L, Vintzileos AM, Rodis JF, Egan JFX, Wolf EJ, McLean DA: Transverse cerebellar diameter measurements in twin pregnancies and the effect of intrauterine growth retardation. Am J Obstet Gynecol 167:982-5, 1992

65. Wolf EJ, Vintzileos AM, Rosenkrantz TS, Rodis JF, Lettieri L, Mallozzi A: A comparison of pre-discharge survival and morbidity in singleton and twin very low birth weight infants. Obstet Gynecol 80:436-9, 1992

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Non-peer Reviewed Publications

1. Rodis JF: Spring is parvovirus time: how to counsel your patients. Ask the Perinatologist. Sarasota Memorial Hospital, Spring 1994.

2. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical and umbilical cord gases. Am J Obstet Gynecol 166:1589, 1992 (Reply to the Editor).

3. Rodis JF, Vintzileos AM: Scanning to diagnose congenital anomalies. Contemp Obstet Gynecol 36:45-54, 1991

4. Rodis JF: Lyme disease in pregnancy. The Unicorn Perinatal Newsletter, 1991, Vol. 1, No. 1.

5. Rodis JF, Vintzileos AM: A sound way to diagnose congenital anomalies. Contemp Obstet Gynecol 36:65-76, 1991

6. Rodis JF, Quinn DL, Garry W, Anderson LJ, Rosengren SS, Cartter M, Campbell WA, Vintzileos AM: Management and outcomes of pregnancies complicated by human B19 parvovirus infection. Clinical Digest Series 2:5-6, 1991.

7. Rodis JF, Vintzileos AM: Congenital heart defects-and other prenatal findings. Contemp Pediatr 8:58-78, 1991

8. Rodis JF, Vintzileos AM: Prenatal diagnosis by ultrasound. Contemp Pediatr 8:77-94, 1991

9. Nochimson DJ, Vintzileos AM, Campbell WA, Rodis JF, Montgomery JT: "Guidelines for Obstetrical Care". The University of Connecticut Health Center, March 1988.

Chapters

1. Rodis JF: Parvovirus Infection. In: Clinical Obstetrics and Gynecology; Roy M. Pitkin, M.D. and James R. Scott, M.D., Eds., Lippincott Williams & Wilkins, Inc., Philadelphia, PA., pp 107-112. 1999

2. Rodis JF: Intraauterine Fetal Demise. In: Fetal Disorders; Editor Boris Petrikovsky, M.D., Ph.D., Wiley and Sons, New York, New York, pp 185-192, 1998

3. Rodis JF: Fetal Infections. In: Fetal Disorders.; Editor Boris Petrikovsky, M.D., Ph.D., Wiley and Sons, New York, New York, pp 249-285, 1998

4. Rodis JF. Multiple Gestation. In: The Physiologic Basis of Gynecologic and Obstetrics, 1st edition, Eds. Seifer, Samuels, Kniss, Williams & Wilkins, Baltimore, MD, 1998

5. Borgida AF, Rodis JF. Twin Pregnancy. In: Quilligan EJ, Zuspan FR, Eds., Current Therapy In Obstetrics and Gynecology 5th Edition. W.B. Saunders, Philadelphia, PA., pp 364-368, 1999

6. Rodis JF: Parvovirus infection in pregnancy. In: Current Obstetric Medicine, Volume 3. Editors Lee, Garner, Barron, Coustan, Mosby-Year Book, Inc., St. Louis. pp159-181, 1995

7. Rodis JF, Vintzileos AM: Parvovirus. In: Viral Diseases in Pregnancy. Ed: Gonik B. Springer-Verlag NewYork, Inc., 1994, 196-214.

8. Vintzileos AM, Campbell WA, Rodis JF: Antepartum fetal assessment by ultrasonography: The fetal biophysical profile. In: Ultrasonography in Obstetrics and Gynecology, Third Edition, Ed. Callen PW, WB Saunders, Philadelphia, 1994, pp 487-502.

9. Vintzileos AM, Campbell WA, Rodis JF: Antepartum surveillance in patients with preterm premature rupture of the membranes, In: Eds. Pitkin RM, Duff P, Clinical Obstet Gynecol, 1991, pp 779-793

10. Vintzileos AM, Campbell WA, Rodis JF: Tests of fetal well being in premature rupture of the membranes, In: Obstet Gynecol Clin North Am, Eds. Weiner CP, Wenstrom KD, WB Saunders, 19:2:281-307, 1992

11. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Clinical Maternal-Fetal Medicine. Editors Winn HN, Hobbins JC, The Parthenon Publishing Group, New York, 2000.

12. Vintzileos AM, Campbell WA, Rodis JF: Percutaneous intrauterine fetal shunting, In: Textbook of Operative Obstetrics. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 110-113

13. Rodis JF, Vintzileos AM: Intrauterine Fetal Death. In: Operative Obstetrics, Second Edition. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 192-203

14. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Antepartum Fetal Assessment. Editor A. Antsaklis (Greece) (In press)

15. Vintzileos AM, Rodis JF: Growth discordancy in twins. In: Abnormal Fetal Growth, Ed. Divon MY, Elsevier Science Publishing Co., New York, 1991, pp 289-317.

16. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile scoring: current status. In: Clinics in Perinatology, Ed. Manning FA, W.B. Saunders Company, 1989 pp 661-689.

17. Campbell WA, Vintzileos AM, Rodis JF, Bors-Koefoed R, Nochimson DJ: The use of beta-blocking agents to treat hypertension during pregnancy. In: Perinatal Pharmacology, Ed. Petrie RH, Oradell, New Jersey, Medical Economics Co. Inc., 1989, pp 151-162.

Invited Regional and National Lectures:

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". New Orleans, LA May, 1998

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". Philadelphia, PA May,1999

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". San Francisco,CA May, 2000

Invited lecturer for the "71st Annual Meeting of the New England Obstetrical & Gynecological Society, Topic – " Shoulder Dystocia", October 20, 1999

Invited lecturer for the "14th Annual: A Day with the Perinatologists – Perspectives in Practice", Sponsored by Creighton University School of Medicine, Omaha, Nebraska. October 22-23, 1999

Invited Lecturer for Ultrasound Symposium, St. Francis Hospital and Medical Center, Topic: Role of Ultrasound Multiple Gestations. Farmington, CT April 8, 2000

Invited Lecturer for the New Jersey Maternal Fetal Medicine Society, New Brunswick, NJ. Topic: Parvovirus Infection in Pregnancy. December 2000

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – Fetal Death: Diagnosis, Evaluation and Management. Chicago, IL May, 2001

Invited Lecturer at the 27th Annual Sanford Cole MD Memorial OBGYN Symposium, Miami, Florida. Late Preterm & Early Term Births: Reducing Elective Deliveries before 39 Weeks. January 25, 2013.

Abstracts

1. Feldman DM, Trymbulak W, Sanders MM, Rodis JF, Borgida AF: Clinical implications of velamentous cord insertion in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

2. Egan JFX, Rodis JF, Feldman DM, Barsoom M, DeRoche M, Borgida AF: Does the Kessler Index reflect trends of Down syndrome livebirths in the U.S.? Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

3. Borgida AF, Dixon A, Feldman DM, Rodis JF, Egan, JFX: Recurrence rate of preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

4. Rodis JF, Feldman DM, Barsoom, M, Herndon A, McKenna P: Antenatal hydronephrosis is a sign of neonatal vesicoureteral reflux. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

5. Rodis JF, Feldman DM, Arky L, Campbell WA, Borgida AF: Normal values of laboratory Tests used in the evaluation of preeclampsia in triplet gestations. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

6. Rodis JF, Feldman DM, Arky L, Campbell WA , Borgida AF: Laboratory evaluation for preeclampsia in triplet pregnancies. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

7. Ling PY, Kong E, Borgida AF, Rodis JF, Egan JFX: Outcome of fetuses with echogenic bowel detected by second trimester ultrasound in a non-referral population. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX : Outcome of pregnancies complicated by ruptured membranes after genetic amniocentesis. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

9. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX: Outcome of pregnancies complicated by second trimester preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

10. Benn P, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

11. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Discordance in sonographically determined estimated fetal weights and birth weights in triplet pregnancies across gestational age.

Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

12. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

13. Benn P, Leo MV, Beazoglou T, Rodis JF: Selecting an optimal strategy for second trimester trisomy 18 screening. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

14. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus Non-rotational Forceps: Maternal and Neonatal Outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

15. Leo MV, Odibo, AO, Ling, PY, Rodis JF, Borgida AF, Campbell WA; Transverse Arrest: a review of Outcomes of Rotational Forceps and Cesarean Delivery at a Single Center. ACOG National Clinical Meeting, New Orleans, LA, May 1998. (Poster presentation)

16. Klein S and Rodis JF - Devoting time to colposcopy: teaching residents what they need to know. 1998 CREOG/APGO Meeting, Orlando, FL, March 4-7, 1998 (Poster presentation)

17. Odibo AO, Campbell WA, Feldman D, Leo MV, Borgida AF, Rodis JF: Resolution of human parvovirus-induced hydrops after intrauterine transfusion. American Institute of Ultrasound in Medicine Annual Meeting, Boston, MA. March 22-25, 1998 (Oral presentation)

18. Gottschall D, Borgida AF, Feldman D, Alberti W, Rodis JF: Preinduction cervical ripening comparing 50 and 100 mcg of misoprostol. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

19. Campbell WA, Feeney L, Fabbri EL, Iannucci P, Borgida AF, Rodis JF, Clive J: Assessment of amniotic fluid index using a curvilinear transducer: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

20. Campbell WA, Sanders M, Rosenkrantz T, Leo MV, Odibo AO, Ling PY, Rodis JF: A center's nine-year outcome experience with congenital diaphragmatic hernia. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

21. Odibo AO, Rodis JF, Sanders MM, Borgida AF, Wilson M , Campbell WA: Correlation of amniotic fluid markers of intraamniotic infection with histopathology in cases of preterm labor: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7 1998. Poster presentation.

22. Odibo AO, Borgida AF, Egan JFX, Rodis JF, Sanders MM, Campbell WA: Relationship of amniotic fluid glucose with histopathologic chorioamnionitis in cases of preterm labor with intact membranes: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

23. Odibo AO, Borgida AF, Rodis JF, Sanders MM, Leo MV, Campbell WA: The relationship of gestational age to histologic chorioamnionitis in preterm labor with intact membranes. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

24. Rodis JF, Borgida AF, Wilson M, Egan JFX, Leo MV, Odibo AO, Campbell WA: Management of Parvovirus Infection in Pregnancy and Outcomes of Hydrops: A Survey of SPO Members. Society of Perinatal Obstetricians, Miami, FL, February 2-7, 1998 (Poster presentation)

25. Rodis JF, Rodner C, Hansen A, Borgida A, Spivey G, and Rosengren S. Long-term outcome of children following maternal human B19 parvovirus infection. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Oral presentation)

26. Rodis JF, McIlveen P, Egan JFX, Borgida AF, Turner GW and Campbell WA. Monoamniotic twins: improved perinatal survival with accurate prenatal diagnosis and antenatal fetal surveillance. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Poster presentation)

27. Benn PA, Borgida AF, Horne D, Briganti S, and Rodis JF. Maternal serum screening efficiency using ultrasound dating versus LMP dating. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

28. Gottschall D, Borgida AF, Mihalek JJ, Sauer F, Rodis JF. Misoprostol versus Prostin E2 gel for preinduction cervical ripening. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

29. Mihalek JJ, Borgida AF, Gotschall D, Rodis JF. Incidence of prolonged bleeding time and its association to other routine laboratory tests. American College of Obstetricians and Gynecologists, Denver CO., May 1996. (Poster presentation)

30. Karak PK, Borgida AF, Brown SL, Rodis JF, Erkmen Z, Henken ML. Polyhydramnios: a pictoral display of associated fetal structural anomalies. American Roentgen Ray Society, San Diego, May 1996. (Poster presentation)

31. Rodis JF, Rinaldi LM, Cusick W, White C: Continuity clinics in obstetrics and gynecology residency programs: one institution's experience. 1996 CREOG and APGO Annual Meeting, Albuquerque, New Mexico, March 1996. (Poster presentation)

32. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for trisomy 21 in second trimester fetuses. American Institute of Ultrasound, New York City, March, 1996. (Oral presentation)

33. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery levels of interleukin-6 (IL-6) and soluble intracellular adhesion molecule-1 (SICAM-1) with umbilical arterial blood gas measurements. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

34. Smulian JC, Bhandari V, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1 with neonatal hematologic indices and early sepsis. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

35. Smulian JC, Campbell WA, Ernst L, Vintzileos AM, Rodis JF: The relation of umbilical vein interleukin-6 and soluble intracellular adhesion molecule-1 to histologic placental inflammation. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

36. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation between umbilical artery and umbilical vein levels of interleukin-6 and soluble intracellular adhesion molecule-1. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

37. Vintzileos AM, Campbell WA, Rodis JF, Guzman ER, Smulian JC, McLean DA: The use of second trimester genetic sonogram in guiding clinical management of patients at increased risk for fetal trisomy 21. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Oral presentation)

38. Vintzileos AM, Egan JFX, Smulian JC, Campbell WA, Guzman ER, Rodis JF: Adjusting the risk for Trisomy 21 by a simple ultrasound method using fetal long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

39. Campbell WA, Vintzileos AM, Smulian JC, Rodis JF, Guzman ER, Egan JFX: Ultrasound to detect trisomy 21 using transverse cerebellar diameter and long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996.

40. Rodis JF, Rodner C, Borgida AF, Spivey G, Shulman-Rosengren S, Campbell WA. Long-term outcome of children following maternal parvovirus infection. Society of Perinatal Obstetricians, Hawaii, February, 1996.

41. Borgida AF, Eng F, Egan JFX, Rodis JF, Smeltzer JS, Turner GW, Campbell WA: Umbilical cord gas assessment in high risk twin gestations. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

42. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for Trisomy 21 in second trimester fetuses. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

43. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Gynecologic Investigation, Chicago, March, 1995.

44. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. American Institute for Ultrasound in Medicine, San Francisco, March, 1995.

45. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? New England Perinatal Society, Vermont, February, 1995. (Oral presentation)

46. Smulian JC, Feeney L, Fabbri EL, Rodis JF, Campbell WA: Second trimester sonographic prediction of fetal gender. Society of Perinatal Obstetricians, Atlanta, January, 1995.

47. Smulian JC, Campbell WA, Rodis JF, Feeney L, Fabbri EL: Gender specific second trimester biometry. Society of Perinatal Obstetricians, Atlanta, January, 1995.

48. Vintzileos AM, Campbell WA, Guzman E, Rodis JF, Rosenberg J: The use of "genetic sonogram" in fetuses at high risk for trisomy 21: Preliminary results. Society of Perinatal Obstetricians, Atlanta, January, 1995.

49. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? Society of Perinatal Obstetricians, Atlanta, January, 1995. (Poster presentation)

50. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Perinatal Obstetricians, Atlanta, January, 1995.

51. Hardardottir H, Kelly K, Bork MD, Cusick W, Rodis JF, Campbell WA: Atypical presentation of preeclampsia in high-order multifetal gestation. Society of Perinatal Obstetricians, Atlanta, January, 1995.

52. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. Society of Perinatal Obstetricians, Atlanta, January, 1995.

53. Borgida A, Rodis JF, Hanlon W, Craffey A, Ciarleglio L, Campbell WA: A prospective randomized trial comparing intramuscular 15 methyl-prostaglandin F2a to intravaginal prostaglandin E2 for second-trimester pregnancy termination. Society of Perinatal Obstetricians, Atlanta, January, 1995.

54. Rodis JF, Ciarleglio L, Egan JFX, Campbell WA, Vintzileos, AM: Women's intuition: Fact or fiction? 23rd Annual Meeting of American Society for Psychosomatic Obstetrics and Gynecology, Washington, DC, February, 1995. (Poster presentation)

55. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. American College Obstetricians and Gynecologists, Orlando, May, 1994

56. Cusick W, Ciarleglio L, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for both open neural rube defects and down syndrome. American College Obstetricians and Gynecologists, Orlando, May, 1994

57. Ciarleglio L, Cusick W, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for trisomy eighteen. Society of Perinatal Obstetricians, Las Vegas, January 1994.

58. Cusick W, Salafia C, Rodis JF, Campbell WA, Vintzileos AM: Low dose aspirin therapy and placental pathology in women with prior poor pregnancy outcomes. Society of Perinatal Obstetricians, Las Vegas, January 1994.

59. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. Society of Perinatal Obstetricians, Las Vegas, January 1994.

60. Cusick W, Ciarleglio L, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for both open neural rube defects and down syndrome. Society of Perinatal Obstetricians, Las Vegas, January 1994.

61. Smulian J, Vintzileos AM, Ciarleglio L, Rodis JF, Campbell WA: Gender-specific patterns of long-bone measurements in fetuses with trisomy 21. Society of Perinatal Obstetricians, Las Vegas, January 1994.

62. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Society of Perinatal Obstetricians, Las Vegas, January 1994.

63. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Third World on Ultrasound in Obstetrics and Gynecology, Las Vegas, October, 1993.

64. Campbell WA, Yamase HA, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique Development. International Fetal Medicine and Surgery Society, April, 1993, (Oral presentation)

65. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. American Institute of Ultrasound in Medicine, 37th Annual Convention, March, 1993.

66. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. New England Perinatal Society, February 1993. (Oral presentation-Ross Award for Best Clinical Oral Presentation and Abstract)

67. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. New England Perinatal Society, February, 1993. (Oral presentation)

68. Rodis JF, Lettieri L, McLean DA, Cusick W, Smulian J, Campbell WA, Vintzileos AM: A new method to correct the incarcerated retroflexed, retroverted gravid uterus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

69. Campbell WA, Vintzileos AM, Rodis JF, Ciarleglio L, Craffey A: Ability of biparietal diameter/femur length ratio to detect down syndrome in patients with an abnormal biochemical screen. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

70. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

71. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

72. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. Society of Perinatal Obstetricians, San Francisco, February, 1993.

73. Cusick W, Vintzileos AM, Varvarigos I, Verikios N, Tassis S, Rodis JF: Mixed umbilical cord blood gas measurements. Society of Perinatal Obstetricians, San Francisco, February, 1993.

74. Cusick W, Vintzileos AM, Rodis JF, McMahon M: The use of second trimester fetal growth curves in predicting intrauterine growth retardation in cases of unexplained maternal serum alpha fetoprotein elevations. Society of Perinatal Obstetricians, San Francisco, February, 1993.

75. Mallozzi A, Egan JFX, Attar E, Feeney L, Ciarleglio L, Rodis JF, Lettieri L, Vintzileos AM: Down Syndrome risk modification based on ultrasound. Society of Perinatal Obstetricians, San Francisco, February, 1993.

76. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained maternal serum alpha fetoprotein elevations. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

77. Lettieri L, Vintzileos AM, McLean DA, Rodis JF, Campbell WA, Wolf EJ: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Presented - Poster session)

78. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

79. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Mead J, Gray S: Does the pregnancy complication resulting in preterm delivery influence predischarge survival and morbidity? New England Perinatal Society, February, 1992. (Presented-Oral session)

80. Albini SM, Cusick W, Rodis JF, Lettieri L, McMahon M, Vintzileos AM: Routine amniocentesis is not indicated to evaluate an unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

81. Cusick W, Rodis JF, Vintzileos AM, Albini SM, McMahon M, Campbell WA: Pregnancy outcome by the degree of maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

82. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

83. Egan JFX, Vintzileos AM, Turner GT, Rodis JF, Campbell WA, Wolf EJ, Balducci J, Lettieri L, Mead J: Correlation of uterine fundal height with ultrasound in twin gestations. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

84. Rodis JF, Wolf EJ, Lettieri L, Scribner D, Campbell WA, Vintzileos AM: Management and outcome of severe preeclampsia in 209 preterm pregnancies. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992

85. Rodis JF, Vintzileos AM, Albini M, Nardi DA, Feeney L, Lettieri L, Wolf EJ, Ciarleglio L: Transverse cerebellar diameter measurements in second trimester fetuses with trisomy 21 and trisomy 18. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

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87. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Lettieri L, Mallozzi A: A comparison of predischarge survival and morbidity in singleton and twin very low birthweight infants. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

88. Campbell WA, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, Nardi DA: Use of the transverse cerebellar/abdominal circumference ratio to identify growth retarded fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

89. Campbell WA, Yamase HT, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique development. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

90. Campbell WA, Vintzileos AM, Rodis JF, Nochimson DJ: Birthweight outcome in pregnancies complicated by an elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

91. Turner GW, Vintzileos AM, Nardi DA, Feeney L, Campbell WA, Rodis JF: Neck circumference measurements in second trimester fetuses with Down syndrome. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

92. Lettieri L, Vintzileos AM, Rodis JF, Campbell WA: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

93. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session

94. Wolf EJ, Egan JFX, Rodis JF, Vintzileos AM, Miller R: Intravenous adenosine for the treatment of maternal paroxysmal supraventricular tachycardia. Armed Forces District, American College of Obstetricians and Gynecologists and Organization for Obstetric, Gynecologic and Neonatal Nurses. Cincinnati, Ohio, October 6-10, 1991.

95. Vintzileos AM, Fleming AD, Scorza WE, Wolf EJ, Balducci J, Campbell WA, Rodis JF: Relationship between fetal biophysical activities and umbilical cord blood gases. Society for Gynecologic Investigation, San Antonio, March, 1991.

96. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. New England Perinatal Society, Vermont, February, 1991.

97. Campbell WA, Cusick W, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, McLean DA: Outcome of quadruplet pregnancies using early hospitalization. New England Perinatal Society, Vermont, February, 1991.

98. Rodis JF, Vintzileos AM, Fleming AD, Ciarleglio L, Nardi DA, Feeney L, Scorza WE, Campbell WA, Ingardia C: Comparison of humerus length versus femur length in fetuses with Down syndrome. New England Perinatal Society, Vermont, February, 1991.

99. Wolf EJ, Mallozzi A, Rodis JF, Egan JFX, Vintzileos AM, Campbell WA, Lettieri L: Placenta previa is not an independent risk factor for IUGR. New England Perinatal Society, Vermont, February, 1991.

100. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm births of twins at a referral tertiary care center. New England Perinatal Society, Vermont, February, 1991.

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103. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm birth of twins at a referral tertiary care center. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

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106. Balducci J, Rodis JF, Rosengren S, Vintzileos AM, Davis G, Vosseller C: Neonatal outcome after first trimester varicella infection. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

107. Fleming AD, Salafia CM, Vintzileos AM, Rodis JF, Campbell WA, Bathan KF: The relationships among umbilical artery velocimetry, fetal biophysical profile and placental inflammation in preterm PROM. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

108. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

109. Scorza WE, Nardi DA, Vintzileos AM, Fleming AD, Rodis JF, Campbell WA: The relationship between umbilical artery Doppler velocimetry and fetal biometry. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

110. Vintzileos AM, Egan JFX, Rodis JF, Campbell WA, Wolf EJ, Balducci J: Clinical characteristics and significance of nuchal cord. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

111. Fleming AD, Rodis JF, Vintzileos AM, Ingardia C, Scorza WE, Ciarleglio L, Craffey A, Feeney L, Nardi D: Comparison of humerus length versus femur length in fetuses with Trisomy 21 and Trisomy 18. Society of Perinatal Obstetricians (SPO), San Francisco, January, 1991.

112. Vintzileos AM, Egan JFX, Campbell WA, Rodis JF, Scorza WE, Fleming AD, McLean DA: Asphyxia at birth as determined by cord blood pH measurements and correlation with neonatal outcomes. New England Perinatal Society, Vermont, February, 1990.

113. Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Egan JFX, Fleming AD, Scorza WE: The relationship between fetal biophysical assessment, umbilical artery velocimetry and fetal acidosis in patients undergoing cesarean section prior to the onset of labor. New England Perinatal Society, Vermont, February, 1990.

114. Fleming DA, Salafia C, Vintzileos AM, Rodis JF, Campbell WA, Bantham KF: The relationships among umbilical arterial velocimetry, fetal biophysical profile and placental inflammation in preterm premature rupture of the membranes. New England Perinatal Society, Vermont, February, 1990.

115. Rodis JF, Ciarleglio L, Petrikovsky BM, Egan JFX, Campbell WA, Vintzileos AM: Women's intuition: fact or fiction? Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

116. Rodis JF, Egan JFX, Craffey A, Greenstein R, Vintzileos AM: Calculated risk of chromosomal abnormalities in twin gestations. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

117. Campbell WA, Nardi DA, Vintzileos AM, Rodis JF, Egan JFX, McLean DA, Turner GW: The bicerebellar/abdomen ratio: as a gestational age independent method of assessing fetal growth. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

118. Vintzileos AM, Egan JFX, Campbell WA, Rodis JF, Scorza WE, Fleming AD, McLean DA: Asphyxia at birth as determined by cord blood pH measurements and correlation with neonatal outcomes. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

119. Fleming AD, Salafia CM, Vintzileos AM, Rodis JF, Campbell WA, Bantham KF: The relationships among umbilical arterial velocimetry, fetal biophysical profile and placental inflammation in preterm premature rupture of the membranes. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

120. Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Egan JFX, Fleming AD, Scorza WE: The relationship between fetal biophysical assessment, umbilical artery velocimetry and fetal acidosis in patients undergoing cesarean section prior to the onset of labor. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

121. Hudgins L, Wilson-Miller K, Quinn D, Rodis JF, Cartter M, Rosengren S. Is human parvovirus B19 teratogenic: follow up on 39 infected pregnancies. Clinical Genetics, Oct 1989.

122. Vintzileos AM, Petrikovsky BM, Campbell WA, Rodis JF, Pinette MG, Egan JFX: Cord blood gases and abnormal fetal biophysical assessment in preterm premature rupture of the membranes. Society of Gynecologic Investigation (SGI), March 1989.

123. Vintzileos AM, Petrikovsky BM, Campbell WA, Rodis JF, Pinette MG, Egan JFX: Comparison of six different ultrasonic methods for predicting lethal fetal pulmonary hypoplasia. New England Perinatal Society, February, 1989.

124. Petrikovsky BM, Vintzileos AM, Nardi DA, Rodis JF, Campbell WA, Hoegsberg B: Association between elevated MSAFP and fetal obstructive uropathy changes. Society of Perinatal Obstetricians (SPO) New Orleans, February, 1989.

125. Campbell WA, Vintzileos AM, Rodis JF, Nochimson DJ, Ciarleglio L: Low maternal serum alpha fetoprotein and abnormal biparietal diameter/femur length ratio to screen for Down syndrome. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

126. Fleming AD, Salafia CM, Rodis JF, Vintzileos AM, Campbell WA: Relationship between umbilical systolic-diastolic ratio, fetal biophysical profile and histologic umbilical vasculitis. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

127. Rodis JF, Vintzileos AM, Campbell WA, Pinette MG, Nochimson DJ: Intrauterine fetal growth in discordant twin gestations. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

128. Rodis JF, Vintzileos AM, Campbell WA, Pinette MG, Nochimson DJ: Intrauterine fetal growth in concordant twin gestations. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

129. Rodis JF, Quinn DL, Garry W, Anderson LJ, Rosengren S, Vintzileos AM, Campbell WA: A large prospective study of human B19 parvovirus infection in pregnancy. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

130. Vintzileos AM, Campbell WA, Rodis JF, Nochimson DJ, Pinette MG, Petrikovsky BM: Comparison of six different ultrasonic methods for predicting pulmonary hypoplasia. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

131. Rosengren S, Quinn DL, Rodis JF: Fetal hydrops and congenital anomalies in association with human parvovirus infection in pregnancy. Teratology Society Meeting, 1988.

132. Rodis JF, Hovick TJ, Quinn DL, Vintzileos AM, Campbell WA, Shulman-Rosengren S, Tattersall P: Human parvovirus infection in pregnancy. New England Perinatal Society Annual Meeting, February, 1988.

133. Vintzileos AM, Campbell WA, Rodis JF, Bors-Koefoed R, Nochimson DJ: Fetal weight estimation formulas using head, abdomen, femur and thigh circumference measurements. Society of Perinatal Obstetricians (SPO), February, 1987.

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PROFESSIONAL SUMMARY

Primary Focus: long-range strategic financial planning focusing on building balance sheet strength; improving the consistency and timeliness of financial information; maximizing the System's inherent strength to improve contracting leverage, purchasing power, balance sheet reserves for program/facility development, maintaining external relationships with creditors, improving access to capital, and development of staff.

PROFESSIONAL EXPERIENCE

7/12 – present **Saint Francis Care / Saint Francis Hospital and Medical Center,** Hartford, CT

An integrated health delivery system, including 617-bed Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital, an independent rehabilitation hospital. Other system affiliates include a specialist and primary care physician group, behavioral health center, and urgent care and other access centers. The Medical Center discharges over 32,000 inpatients and treats over 500,000 outpatients annually.

SENIOR VP AND CHIEF FINANCIAL OFFICER **December 2014**

Responsible for daily financial operations, revenue cycle, supply chain, budgeting, cost accounting, and treasury functions.

SENIOR VICE PRESIDENT OF FINANCE **February 2014**

Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Successfully negotiated additional reimbursement of over $10 million over two years for the Hospital and Medical Center
- Identified and achieved cost savings of the state provider tax, resulting in additional net income to the health system of over $2 million annually
- Participate in Connecticut Hospital Association's committee on hospital finance and subcommittee on all-payor reimbursement diagnosis related group (ARP-DRG), which assisted the state's transition to modernize its reimbursement.
- Successfully negotiated a $0.5 million reduction in pharmacy overpayments
- Started the Health System's Investment Committee

VICE PRESIDENT OF FINANCE **July 2012**

Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Led the refinancing of $213 million of tax-exempt bonds into private placement debt in collaboration with seven different lending institutions
- Established service line reporting structures to educate physician and executive directors on financial and operational performance.
- Oversee the annual financial statement audit for the health system

8/07 – 7/12 **Memorial Health System,** Springfield, IL

An integrated health delivery system, including 500-bed Memorial Medical Center, Abraham Lincoln Memorial and Taylorville Memorial Hospitals, 25-bed Critical Access hospitals. Other system affiliates include home services and hospice, primary care physician group, mental health centers, urgent care centers, and property management. Annual net operating revenues were $736 million, generating a 2.6% operating margin in FY 2011(5.6% operating margin in FY 2010). The Medical Center discharges over 25,700 inpatients and treats over 490,000 outpatients annually.

DIRECTOR OF FINANCE & GENERAL ACCOUNTING

Responsible for daily financial operations, budgeting, cost accounting, charge description master, property management, treasury functions, and finance information services.

- In FY2012, collaborated with the CFO and Investment Committee to develop a $90 million new money financing plan to provide funds for two new medical office building projects; maintained A+/A1 category credit ratings by S&P and Moody's credit rating agencies.
- In FY2012, collaborated with the COO and his VP team to develop and implement monthly flexible budget to actual reporting, increasing the accountability and involvement of operational leaders in their departments' financial performance.
- Participated with the Investment Committee to review and monitor investment portfolios of over $450 million, which have outperformed the benchmark by over 27 basis points and 190 basis points for the Medical Center investments and Health System Pension investments, respectively.
- Participated in several cost savings initiative teams to reduce operating expenses, increase revenue, and develop financial reporting metrics, which led to a 2% increase in productivity (or approximately $3.2 million in salary costs) and a 20% (or $400,000) reduction in overtime.
- Led various multi-disciplinary Lean / Six Sigma teams within the supply chain, materials management, and the revenue cycle, reducing annual freight costs by over $100,000 and decreasing bad debt expense of the primary care physician group by over 50%.
- In FY 2009, collaborated with the CFO and operational leaders to complete a $150 million financing plan that issued tax-exempt bonds for use by the Medical Center and both Critical Access Hospitals; developed and implemented a credit rating strategy that secured an A+/A1 category rating from S&P and Moody's credit rating agencies.

Ernst & Young, Kansas City, MO **June 2005 – August 2007**
Manager, Assurance and Advisory Services

Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, E&Y employs over 152,000 people.

Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $100 million to over $4 billion, participated in audit committee and board of director meetings, counseled younger staff in career development, including training of new staff and seniors, managed several teams and projects simultaneously, and participated in health care tax-exempt bond issuances and other health care consulting engagements.

BKD, LLP, Kansas City, MO **July 1999 – June 2005**
Manager, Assurance and Advisory Services

BKD, LLP is a top ten CPA and advisory firm that operates 30 offices in the Midwest. BKD employs over 2,000 professionals.
Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $25 million to over $500 million, presented audit reports and management letters to finance committees and board of directors' meetings, supervised, trained, and reviewed the work of staff accountants, and mentored several staff accountants to establish career goals.

EDUCATION

Bachelor of Science, 1999, Truman State University

Master of Business Administration, 2009, Benedictine University

CERTIFICATIONS

- Certified Public Accountant Exam (passed on first attempt)
- Six Sigma Green Belt Certification
- Certified Healthcare Financial Professional

PROFESSIONAL AND CIVIC AFFILIATIONS

- President of Lincoln Land Drug Awareness Resistance Education (DARE)
  - 2007-2010
- Treasurer and Board Member of Ronald McDonald House Charity of Central Illinois
  - 2011 - 2012
- Fellow of Healthcare Financial Management Association
    - 2011 – Current
    - Treasurer, Board Member, and Sponsorship Chair of McMahon HFMA chapter
- Adjunct Accounting Faculty at the University of Illinois at Springfield
  - 2010 – 2012
- Finance Committee Member of Food Share
  - 2012 - Current

RICHARD J. GILFILLAN, MD, MBA

Professional Accomplishments

Trinity Health **November 2013 – Present**

President & Chief Executive Officer

Trinity Health is the second largest Catholic health system in the nation and fourth largest health system overall in the U.S. and operates 86 acute care hospitals, 44 home care agencies, 14 PACE centers, 70 other continuing care facilities in 20 states. Employs nearly 87,000 people including 3,300 employed physicians and 21,600 affiliated physicians. Trinity Health reported $13.6 billion in net revenues in FY2014. The ministry was formed in May 2013 with the coming together of Trinity Health and Catholic Health East. Trinity Health is sponsored by Catholic Health Ministries, a governance entity established by the Catholic Church to oversee the healing ministry and Catholic identity of Trinity Health.

Centers for Medicare and Medicaid Services **August 2010 – July 2013**

Acting Director and Director
Center for Medicare and Medicaid Innovation **September 2010 – July 2013**

Directed the development and operations of this new Center within CMS charged with identifying, testing and spreading new service delivery and payment models that reduce program expenditures while improving the quality of care for Medicare, Medicaid and CHIP beneficiaries

Accomplishments:

- Created initial strategic and operating plan and obtained first year funding
- Created effective leadership team and directed the hiring of 150 new team members
- Merged the Office of Research, Development and Information with 80 staff members into the Center
- Directed the design of key Center operational activities and processes
- Directed and participated in national campaign to introduce the Center's role and approach
- Directed the development and implementation of new CMS model initiatives including Pioneer ACOs, Comprehensive Primary Care, Bundled Payment for Care Improvement, Partnership for Patients, End Stage Renal Disease, Innovation Awards Rounds 1 and 2, State Innovation Models, and Independence at Home, that engaged over 50,000 providers caring for more than 2 million Medicare and Medicaid beneficiaries
- Participated in development of CMS ACO Shared Savings and Dual Eligibles Initiatives
- Established effective working relationships with key partners across the Administration
- Represented CMS in Congressional meetings including testifying before the Senate Finance Committee

Director

Performance-based Payment Policy Staff **August 2010 – October 2010**

Directed the staff responsible for establishing regulations for the Medicare Shared Savings Accountable Care Organization (ACO) Program, the Hospital Value Based Purchasing initiative, the Physician Value Modifier initiative, and other performance-based payment programs. After 8 weeks in this position was asked by the Administrator to assume the position of Acting Director of the Innovation Center.

Accomplishments:

- Oversaw initial development of Shared Savings ACO Regulation
- Developed proposed Quality performance measurement system for ACO Regulation
- Represented CMS in more than 30 meetings with outside parties
- Built relationships with key partners across CMS
- Developed management team and rapidly hired additional staff

Geisinger Health System, Danville Pa. **August 2005 – July2010**

Consultant, Washington DC **July 2009 – July 2010**
Geisinger Consulting Services

Provided consulting services to health care systems and payer organizations regarding the design and implementation of alternative care systems, such as Accountable Care Organizations and Patient Centered Medical Homes

Accomplishments:
- Developed an ACO model for the leading national ACO Collaborative
- Participated in marketing and recruitment campaign for ACO Collaborative that led to more than 60 participating institutions
- Designed a capabilities assessment tool that allows health systems to identify change priorities for creating ACOs
- Led a consultant team supporting client in implementing the Collaborative
- Developed strategic approach for a large health system change initiative
- Designed a series of guidebooks for health systems to use to plan transformation to accountable care
- Developed plan for a large labor union fund to significantly reduce their medical expenditures
- Provided input to Obama Administration staff and Members of Congress on healthcare reform

President & CEO Geisinger Health Plan **July 2005 – June 2009**
EVP Insurance Operations Geisinger Health System

Had P & L responsibility for the $1 Billion Insurance Operations of this Integrated Health System and participated on the Executive Leadership Team that oversaw System operations.

Accomplishments:
- Created a well integrated management team that produced outstanding results for 4 years including:
    - Growing membership by 25%
    - Significantly exceeding financial goals for four years

- Improving Quality improvement results that raised Plan's national ranking from 33rd to top 10 for 3 years.
- Helped to design ProvenCare, an innovative care redesign/bundled payment model for specialty care
- Helped to design Proven Health Navigator, an innovative care redesign and payment model for primary care
- Expanded Plan service area to double market size
- Improved the relationship between Health Plan and System Clinical Leadership to create a partnership that enabled our efforts to build innovative care and payment models
- Achieved Outstanding Accreditation from the National Committee for Quality Assurance (NCQA)

Coventry Health Care, Bethesda, MD **2001 - 2005**

Senior Vice President National Network Management

Responsible for the Network Contracting and Medical Cost Management operations for this $3 billion national managed care organization.

Accomplishments:
- Oversaw National Contracting team responsible for contracts with 5,000 hospitals and 600,000 physicians in 50 states
- Created corporate wide Medical Cost Management process that improved medical cost trend
- Developed an innovative Primary Care delivery and reimbursement model with independent physicians in three markets
- Developed new Fraud, Abuse and Claims Recovery programs

Independence Blue Cross, Philadelphia, Pa **1989 - 2000**

General Manager
AmeriHealth HMO & Insurance Company, Mount Laurel, NJ **1995 – 2000**

Profit and Loss responsibility, including start-up, for a new managed care subsidiary

Accomplishments:
- Profitably grew the business over 5 years to $300 Million Revenue base and 300,000 Commercial, Medicare and Medicaid members
- Built successful leadership team and grew staff from 15 to over 150
- Instituted quality improvement programs that led to # 1 State ranking for three years
- Oversaw the successful implementation of a new enterprise wide computer operating system.
- Directed the development of a new corporate medical informatics system

Chief Medical Officer and Senior Vice President
Independence Blue Cross and Subsidiaries, Philadelphia, PA **1992-1995**

Oversaw the medical management activities for all subsidiaries of this $3 Billion Blue Cross plan with approximately 3 million members

Accomplishments:
- Merged the medical management function of three HMO's into one 300 person staff
- Created state of the art quality, utilization and medical cost management functions
- Achieved full accreditation from the National Committee for Quality Assurance

- Developed innovative, first in the nation contact capitation program for cardiology care

Medical Director and Senior Vice President
Keystone Health Plan East **1989 – 1995**

Oversaw the medical and network management activities for this start-up HMO

Accomplishments:
- Established new Medical Management and Provider Relations Teams
- Helped directed expansion of the provider network to include 8,000 physicians and 60 hospitals
- Developed innovative Disease Management Programs
- Instituted an innovative radiology capitation program that decreased costs by 30%
- Developed one of the first in the nation commercial Resource Based Relative Value System (RBRVS) physician fee schedules that decreased costs by approximately 20%
- Achieved full NCQA accreditation

New Jersey Blue Cross and Shield **1985 – 1989**

Medical Director and Primary Care Physician
Medigroup Central HMO Trenton, NJ

Created network and medical management functions and practiced adult and pediatric primary care medicine half-time in inner city Trenton for a staff/network model HMO

Accomplishments:
- Established a new Independent Physician Association (IPA) division and management team
- Built provider network that included 15 hospitals and 500 physicians
- Led a reengineering initiative in staff primary care sites to improve waiting times
- Improved customer satisfaction in the staff model
- Established innovative mental health carve-out contract that improved care and lowered costs

Winchendon Community Health Center, Winchendon Ma **1980 – 1985**

Medical Director and Family Practitioner

Practiced full time adult, pediatric and obstetrical care and was the medical director in a small, rural poor community in Central Massachusetts.

Accomplishments:
- Built a new family medicine group practice of three physicians
- Led the conversion of a 28 bed town hospital into a Community Health Center
- Served as Secretary and Treasurer of the medical staff at parent hospital
- Established academic relationship with Medical School

Georgetown University Community Health Plan, Washington, DC **1979 – 1980**

Primary Care Family Physician

Education

The Wharton School of the University of Pennsylvania, MBA	**1992**
Hennepin County Medical Center, Family Practice Residency	**1979**
Georgetown University School of Medicine School, MD	**1976**

Georgetown University School of Foreign Service, BSFS **1971**

Board Activities:

Alliance of Community Health Plans Board of Directors **2007 – 2009**
Director on the Board of this industry Association of not-for-profit managed care organizations that includes Kaiser, Health Partners and 11 other Health Plans

Geisinger Insurance Operations Boards of Directors **2005 - 2009**
Director on the Boards of the three companies that make up Geisinger Insurance Operations

Geisinger Health Science Foundation Board of Directors **2005 – 2009**
Participated in quarterly meetings and provided updates on the performance of the Insurance Operations

New Jersey State Chamber of Commerce Board of Directors **1996 - 2000**
Director on a Board made up of CEO's and senior executives from large New Jersey companies including Prudential, Bell Atlantic, AT&T and Johnson & Johnson

AmeriHealth New Jersey Board of Directors **1995 - 2000**
Made quarterly presentations to HMO Board regarding overall strategy and results

Vice Chairman, Princeton Regional Health Commission **1992 – 1995**
Participated in and chaired monthly public meetings of the Commission overseeing public health for Princeton, NJ

Keystone Health Plan East Board of Directors **1989 – 1995**
Presented medical and quality management reports to a Board that included the IBC CEO and external directors representing large community employers

Medigroup Central Board of Directors **1985 – 1989**
Director on the Board overseeing the HMO subsidiary of New Jersey Blue Cross

Winchendon Hospital Board of Directors **1980 – 1985**
Director and member of the Hospital Executive Committee that negotiated a merger with another community hospital.

BENJAMIN R. CARTER, CPA, FHFMA

CAREER OBJECTIVE To be a CEO and Regional Leader of a large Diversified and Integrated Health Care Delivery System

EDUCATION: MBA, 1992; University of Michigan (Magna Cum Laude)
BBA, 1980; University of Michigan (Magna Cum Laude)

WORK EXPERIENCE:

May, 2013 – Present

Trinity Health; Livonia, MI
Executive Vice President and CFO/Treasurer
Responsible for the System strategic and financial operation of the 21 state Trinity Health System. Trinity Health is the second largest Catholic Health Care System in the country with total net revenues exceeding $13.5 Billion, including over 82 hospitals, 89 continuing care facilities, the largest not for profit home health agency in the country, and over 3100 employed physicians.

Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management, third party contracting and strategic payor alliances. Responsibilities also include Treasury services and asset management for $16 Billion of investable assets, debt management for $5 Billion of long term debt, investor relations, and Insurance and Risk Management Services.

Trinity is AA rated organization with a consistent record of strong operating and non-operating financial results.

March, 2010 – May, 2013

Trinity Health; Novi, MI
Senior Vice President and Chief Financial Officer
Responsible for the system financial operations of the 10 state, $9.0 Billion Trinity Health organization. Prior to merging with Catholic Health East (CHE), Trinity Health was the fourth largest Catholic Health Care system in the country, comprising 49 hospitals, 32 long term care facilities, and a 6 State home health agency. Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management and third party contracting.

Trinity Health was a AA rated organization with superior operating and non-operating performance, exceeding peer group averages.

May, 2005 – March, 2010

Detroit Medical Center; Detroit, MI

Executive Vice President and Chief Operating Officer
Responsible for the system operations of the eight hospitals and related outpatient facilities that comprise the $2 Billion Detroit Medical Center. Responsibilities include oversight of all system support services including Retail Pharmacy, Managed Care Contracting and Operations, University Laboratory and Commercial Operations, Physician Recruitment and Office Practice Management, Information Services, System wide Security, Professional Sports Medicine program, Purchasing and Procurement, and Graduate Medical Education and Centralized Credentialing.

Key accomplishments include turn around of the organization from $100 million annual loses in 2002 and 2003, to six straight years of profitability, including 2009 expected operating income of $40 million. Led key growth, cost reduction, and profit initiatives in multiple service lines contributing to successful turnaround.

1999 – May, 2005

Oakwood Healthcare, Inc.; Dearborn, MI
Chief Financial Officer and Executive Vice President
Responsible for all financial operations of the $860 million healthcare system including: Treasury Management, General Accounting (including accounts payable and payroll), budget and Decision Support, Internal Audit, Legal Services and Information Systems. As a member of the Executive Council, responsibilities include setting corporate policy and overseeing their successful implementation and maintenance. Successfully managed the implementation of a 3-year Financial Viability Plan, restoring the financial performance of the System to historically high levels. In 2004, the System achieved a total margin of $36 million, a 2.0% operating margin, and maintained an "A" rating with a stable outlook.

1997 – May 2005

Oakwood Enterprises, Inc.; Dearborn, MI
President and Executive Vice President, Oakwood Healthcare, Inc.
Responsible for the development and operation of the Oakwood Healthcare, Inc. subsidiary which operates for profit health related businesses and creates joint ventures for the system, including home services and real estate development. Have held a number of executive posts within Oakwood Healthcare, Inc., including Interim Chief Financial Officer and Interim Chief Operating Officer. Member of the Oakwood Healthcare, Inc. Executive Council, which sets policy system-wide, and is responsible for strategic planning and deployment.

1995 – April, 1997

Oakwood Healthcare System; Dearborn, MI
Senior Vice President, Support and Related Services
Responsible for Human Resources, Risk Management and Legal Affairs, Information Services, Quality Assurance, Operations Analysis, Materials Management, Architecture and Construction, and Foundations (since June, 1996) for the Corporation. Total capital and operating budgets in excess of $150 million per year. Reported directly to the Executive Vice President and Chief Operating Officer. Member of the System-wide Transition Team charged with designing the year 2000 Integrated Delivery System. Administrative Coordinator for Facilities/Planning/Technology Assessment Board Committee. Also a member of the Quality Assessment and Improvement Board and continuous Quality Improvement Steering Committee.

1991 – 1994

Oakwood United Hospitals, Inc.; Dearborn, MI
Senior Vice President and Controller
Responsible for the financial management of a five-hospital system and nursing home, with an annual budget in excess of $200 million. Responsibilities included Treasury Management, budgeting, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer. Also a member of Oakwood Health Services Operations Committee and Continuous Quality Improvement Steering Committee.

1989 – 1990

Oakwood United Hospitals, Inc.; Dearborn, MI
Vice President and Controller
Responsible for the management of the financial operations of a four-hospital system. Responsibilities included Treasury Management, budgeting, financial analysis, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer, and worked closely with the Chief Operating Officer on management issues.

1988 – 1989

Oakwood Hospital Corporation; Dearborn, MI
Vice President of Accounting and Reimbursement
Responsible for the preparation of financial statements of the Hospital and related companies. Responsibilities included management of all reimbursement functions and negotiations of third-party contracts. Also responsible for all not-for-profit and for-profit tax filings.

1986 – 1988 ***Plante & Moran CPAs; Southfield, MI***
Director of Healthcare Services, Southeastern Michigan
Responsible for the management of audit and consulting projects for the firm's healthcare clients, including hospitals, nursing homes, and home health agencies.

1980 – 1986 ***Plante & Moran CPAs; Southfield, MI***
Audit Staff and Associate
Member of the audit staff responsible for completing audits of manufacturing and municipal clients.

BOARDS: (Past examples)

- DMCIC
- DMC Care Express
- Michigan Mobile Imaging
- CareTech Solutions, Inc.
- Oakwood Assurance
- HealthLink
- Invest Michigan Advisory Board

AFFILIATIONS:

Member:

- American Institute of Certified Public Accountants
- Michigan Association of Certified Public Accountants
  - Chair, Healthcare Committee; 1993 – 1995
  - Vice Chair, Healthcare Committee; 1991 – 1993
- Healthcare Financial Management Association
  - Board Member 1989 – 1993
  - Treasurer 1993 – 1994
  - Secretary 1994 – 1995
  - President-Elect 1995 – 1996
  - President 1996 – 1997
- Boys Hope of Detroit, Board Member; Treasurer and Finance Committee Member
- Health Alliance Plan, Board Member – 1985 – 1988
- Michigan Health Management Information Systems
  - Member, Executive Steering Committee
- Michigan Health and Hospital Association
  - Member, Payment Practices Committee
  - Member, Data Task Force
- Greater Detroit Area Health Council
  - Member, Steering Committee; National Health Information Technology Lab
- Joe Dumars Foundation; Treasurer

AWARDS: HFMA (Healthcare Financial Management Association)

- Chapter Achievement Award of Excellence
- Follmer Bronze Merit Award
- Reeves Silver Merit Award
- Muncie Gold Merit Award
- Certified Fellow

Phi Beta Kappa
Beta Alpha Psi
Licensed Nursing Home Administrator

PERSONAL: Married; four children
Enjoy golf, running, basketball and reading
Private pilot; Certified Flight Instructor, Instrument Rated

James Richard O'Connell

SUMMARY OF QUALIFICATIONS

Forty years of progressive healthcare experience with executive level leadership in both corporate and hospital facilities ranging in bed size from 174 to 522. Geographic locations include Oklahoma, Texas, Florida and Colorado. Major strengths in the development of quality; cost efficient programs; team building; medical staff relations; community relationships and board development and involvement. Have had experience in not for profit, faith based and for profit healthcare facilities.

STRENGTHS

Business turnaround and culture change, program development and strategic positioning, physician / hospital relationship development, patient advocacy, associate engagement and community / board involvement.

PROFESSIONAL EXPERIENCE

Trinity Health

Executive Vice President – East Group
July 2014 to present

Executive Vice President-West/Midwest Group
April 2013 to July 2014

Executive Vice President & Chief Operating Officer
October 2008 to April 2013

TRINITY HEALTH
20555 Victor Parkway
Livonia, Michigan

Centura Health

Executive, Development and Community Relations
Feb 2008 to August 2008

PENROSE-ST. FRANCIS HEALTH SERVICES –CENTURA HEALTHCARE
2222 North Nevada Avenue
Colorado Springs, Colorado

After my resignation as CEO of Penrose St Francis Health Systems, Centura requested me to stay on in the position of Executive Development and Community Relations. Responsibilities include representing the hospital on local community boards. Maintaining the positive image that the team established for the hospital and Centura Health in the community. Additionally, led fundraising efforts and managed the construction of a 460,000 foot Saint Francis Medical Center, completed on time and on budget, and opened 8/8/08. Through the development of this 21st century hospital, we created a sense of excitement in the community to gain a cross section of support for this new facility. Continue to foster relationships with community members and leaders to lay the foundation for the success of my replacement.

Centura Health

President and Chief Executive Officer
May 1999 to Feb 2008

PENROSE-ST. FRANCIS HEALTH SERVICES (522 licensed beds)
2222 North Nevada Avenue
Colorado Springs, Colorado

Led this 522 bed, 3 hospital system to world class recognition, financial and quality performance for over nine years.

- Financial Turnaround: From 1999 operating loss of <$8.5> million, to operating income of $53.6 million in 2007
- National Recognition Solucient's 100 Top Hospitals five times
- U.S. News and World Report Best Systems in the Country 2006 and 2007
- HealthGrades Distinguished Award for Clinical Excellence five years running
- HealthGrades America's 50 Best Award Winner 2007
- Three major construction programs all on time and on budget:
  - Audubon Medical Campus and Surgery Center - $23 million
  - Penrose Main Bed Tower and Medical Office Building - $ 67 million
  - St. Francis Medical Center new 465,000 sq. ft. facility (scheduled to open 8/8/08) - $207 million
- Community and Board Relationships: developed positive community relationships through board involvement, public speaking and community program development
- Physician Engagement: Enhanced physician relations through numerous programs, services and joint venture development all focused on improved quality and patient care
- Associate satisfaction improvement in every annual survey
- Patient satisfaction improvement received consumer choice award last two years
- Recognized as Center of Excellence by Payers in both cardiology and bariatrics

Columbia/HCA **President and Chief Executive Officer**
1995 to April 1999

LUCERNE MEDICAL CENTER (267 licensed beds)
818 Main Lane
Orlando, Florida

- Made substantial impact on the public's awareness and positive perception through continuous community involvement and outreach programs
- Gallup Surveys indicate a continuous increase in-patient, physician and associate satisfaction
- Received Key to the City from the Mayor of Orlando for our active, ongoing partnership in community health
- Developed and received approval from the City of Orlando on our 10-year Facility Master Plan
- Developed active relationship in education with The University of Central Florida
- Planned and completed new expanded Emergency Room facilities to better serve the community
- Increased annual open-heart surgical volume from 176 to 400 cases within a three-year time period
- Received JCAHO Accreditation with Commendation in 1996
- Received 3-year CARF accreditation with no recommendations for our 35-bed rehabilitation facility

Columbia/HCA **President and Chief Executive Officer**
1995 (3 months)

COLUMBIA MEDICAL CENTER DAYTONA (214 licensed beds)
400 North Clyde Morris Boulevard
Post Office Box 9000
Daytona Beach, Florida

Responsible for JCAHO preparation and facility staffing reorganization. Columbia Medical Center Daytona subsequently received accreditation with commendation from JCAHO.

Columbia/HCA
President and Chief Executive Officer
1993 - 1995

PEMBROKE PINES HOSPITAL (301 licensed beds)
2301 University Drive
Pembroke Pines, Florida

Responsible for reversing the hospital's multiple year operational deficit into a progressive profit status for 1994 -1995. Spearheaded operational improvements, new programs (neurosurgery, pediatrics, sleep lab and vascular laboratory) and joint venture / lease of facility to Local Hospital District. Hospital EBDITA increased 170% to $2.3 million prior to lease.

Columbia/HCA
Chief Operating Officer
1992 - 1993

MIAMI HEART INSTITUTE (252 licensed beds)
Miami Beach, Florida

Responsible for the pre-acquisition due diligence for the merger of Miami Heart Institute and Miami Beach Community Hospital. The merged facilities had a total of 531 licensed beds. Plans were developed and executed for departmental resource consolidation. Responsible for overall hospital operations. Administrative representative for all medical staff committees.

Columbia/HCA
Chief Operating / Financial Officer
1991 - 1992

MIAMI BEACH COMMUNITY HOSPITAL (273 licensed beds)
Miami Beach, Florida

Responsible for pre-acquisition and post-acquisition success for this 273-bed, full-service, acute care facility. Direct administrative responsibility for all hospital departments. Actively involved in recruitment and retention of physicians. Served as administrative representative on all medical staff committees. Responsible for successful accreditation by JCAHO and other regulatory agencies. Accountable for all financial operations of the hospital.

AMI
Corporate Director of Operations
1990 – 1991

AMERICAN MEDICAL INTERNATIONAL
Dallas, Texas

Developed analytical framework for analysis of hospitals' performances. Prepared financial comparison and analysis reports. Reviewed hospitals' monthly projections against actual results. Worked closely with hospital CEO's and CFO's to identify opportunities for improvement. Reviewed hospital operating budgets for accuracy and completeness. Facilitated budget training classes for administrative staffs of all AMI hospitals. Developed capital budgeting process for all AMI facilities, including internal rate of return analysis.

AMI

Chief Financial Officer
1989 - 1990

AMI MEMORIAL HOSPITAL TAMPA (174 licensed beds)
Tampa, Florida

Responsible for all financial operations of the hospital. Maintained financial records and statistics needed by the hospital and corporate office for evaluating financial performance, satisfying audit requirements and completing governmental reports. Prepared hospital operating and capital budgets. Prepared financial forecasts for corporate office. Assisted and advised all department heads in the analysis of their department's financial results. Established and maintained the appropriate internal controls in all applicable departments.

AMI

Chief Financial Officer
1987 - 1989

AMI PARKWAY REGIONAL MEDICAL CENTER (412 licensed beds)
North Miami Beach, Florida

Responsible for all financial departments of the hospital. Responsible for the preparation of hospital operating and capital budgets. Prepared monthly financial projections for corporate office. Monitored hospital performance to ensure budgeted goals are met; analyzed and explained variances. Responsible for all contract negotiations. Responsible for the operations of two walk-in clinics and a major diagnostic imaging center. Served as administrative representative on various medical staff committees and board of directors.

AMI

Chief Operating / Financial Officer
1985 - 1987

AMI DOCTORS' MEDICAL CENTER (221 licensed beds)
Tulsa, Oklahoma

Direct administrative responsibility for various hospital support and ancillary departments. Prepared hospital operating and capital budgets. Analysis of income and expense statements. Continually monitored hospital's actual performance versus budget. Feasibility analysis for all projects and ventures. Presented financial review to the board of directors. Assisted in physician recruitment and retention, contract negotiations and joint ventures.

AMI

Manager, Business Operations / Controller
1979 - 1985

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Supervised and coordinated the activities of managers and supervisors. Increased productivity and consistency of business related activities. Assisted chief financial officer in the preparation of monthly financial statements and hospital budgets. Responsible for all accounting functions, including accounts payable, accounts receivable, payroll and quarterly / annual reports.

AMI

Data Processing Manager
1975 - 1979

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Responsible for converting the hospital's manual posting system to a computerized system using an IBM System 3 computer. Wrote and maintained more than 400 user programs, ranging from accounts receivable and payable systems to departmental productivity and budgeting systems.

COMMUNITY

Served on community boards including: Chamber of Commerce, Goodwill Industries, Community Health Partnership, Pikes Peak Education Foundation, El Paso County Equestrian Center, Pikes Peak Humane Society and Joint Initiatives for Families and Children. Led the initiative to create a Detox Continuum for El Paso County. Raised over $15 million in community funds for various projects including the John Zay House, a special project to build an 11 suite home for those receiving extended hospital treatment. This is a project sponsored by the Home Builders Association (HBACares) Recognized as Colorado Springs Business Citizen of the Year in 2004 for community involvement.

EDUCATION

Central State University
Edmond, Oklahoma
B.B.A. December, 1975
Major: Business Administration
Special emphasis in Accounting and Business Law

Oklahoma Baptist University
Shawnee, Oklahoma
May 1974 - May 1975
Major: Hospital Administration

REFERENCES

Available upon request

EXHIBIT 14 a

COMMENTARY

Population Health Management: The Intersection of Concept and Reality

CHRISTOPHER DADLEZ, FACHE

THE FEATURE ARTICLES in this issue of *Frontiers* offer different philosophies and approaches to meeting the Triple Aim of the Institute for Healthcare Improvement. Zenty, Bieber, and Hammack document a local and granular means of creating targeted accountable care organizations (ACOs) to make Triple Aim inroads toward ensuring the health of the discrete populations. Their "build on success" approach offers practical insights on developing mission, governance, and analytics to guide the creation of clinically oriented population health programs, in contrast to the "total population health" ambitions of Kindig and Isham.

Over the past five years, Saint Francis *Care* has been working on many of the same issues and initiatives mentioned in both of the feature articles, from population health management to clinical integration to aligning clinical and social services to developing accountable care models for several payers, including our own hospital, Medicare, and private insurers. Along the way, we have encountered the intersection of concept and reality and forged a path forward.

SAINT FRANCIS *Care*

Saint Francis *Care,* an integrated healthcare delivery system in central Connecticut, is the largest independent Catholic healthcare provider in New England. Our services cover the spectrum of patient needs, including community-based preventive and primary care, specialty care, high-acuity tertiary care, and post-acute care. Many of these services are provided through partnerships, affiliations, and relationships developed with other exceptional providers. Overall, Saint Francis *Care* provides access to almost 900 affiliated physicians, three hospital campuses, 12 satellite medical offices, and a variety of community clinics.

Christopher Dadlez, FACHE, is president and CEO of Saint Francis *Care* Inc. in Hartford, Connecticut.

With 617 licensed beds and 65 bassinets, the flagship of Saint Francis *Care* is Saint Francis Hospital and Medical Center in Hartford. The hospital expanded in 2011 with the addition of the ten-story John T. O'Connell Tower, featuring a state-of-the-art surgical pavilion, dedicated space for the Connecticut Joint Replacement Institute (CJRI), and an expanded emergency department (ED) with 70 treatment areas and a rooftop helipad for the LIFESTAR helicopter. In addition to CJRI, Saint Francis offers centers of excellence in cancer care, heart and vascular disease services, rehabilitation medicine, and women and infants' services. Indeed, Saint Francis opened its 24,500-square-foot Comprehensive Women's Health Center in November 2013, a site that combines breast health, heart health, gynecologic care, and integrative medicine services for women.

Our integrated healthcare delivery system also includes the Mount Sinai Rehabilitation Hospital, Connecticut's only free-standing acute care rehabilitation hospital, which shares space on campus with our Mandell Center for Multiple Sclerosis. In addition, Johnson Memorial Medical Center signed an affiliation agreement with Saint Francis in 2012. The central structure for our ACO is Saint Francis HealthCare Partners, a 50:50 physician–hospital partnership that provides clinical integration and comprehensive administrative support to 700 physicians in more than 200 practices.

A Vision for Value

While we have outstanding facilities, we have long recognized that a well-articulated strategy and aligned providers—not bricks and mortar—are the foundation for advancing healthcare delivery. Back in 2009, Saint Francis *Care* embarked on a unique strategic planning process with an eye toward shaping an organization that would be well positioned to thrive in a changing and uncertain healthcare environment. The core working group was small but represented a diverse mix of administrators, physicians, and board members. *The Innovator's Prescription: A Disruptive Solution for Healthcare,* by Christensen, Grossman, and Hwang (2008), was assigned reading for this group.

From this work, we generated a compelling vision: Best*Care* for a Lifetime. The focus was on delivering value for patients across the continuum of care. In other words—and this was a major shift—we explicitly emphasized the importance of what happens outside the hospital. We were setting the stage to work toward accountable care and saw innovation and a coordinated infrastructure as key drivers.

To achieve the vision of Best*Care* for a Lifetime, our strategic plan called for a new organizational structure, with ten service lines that would set their sights to include the pre-acute/preventive, hospital, and post-acute environments: Behavioral Health, Cardiovascular, CJRI, Emergency Medicine, Medicine, Oncology, Physical Medicine and Rehabilitation, Primary Care, Surgery, and Women and Infants. The work of these service lines is facilitated by robust support platforms that include Business, Clinical Services, and Facilities, as well as our award-winning Innovation + Learning Center. As we had no illusions that a service line model of care was the only key to achieving our vision, the strategic plan also called for becoming a value provider and developing a geographic presence.

By adopting the definition of *value* as outcomes that matter to patients per dollars spent, we leveraged our new organizational structure to focus on the needs of our patients and communities across the continuum of care. To support our

increased emphasis on value, two dozen physicians and executives from Saint Francis have attended Harvard Business School courses presented by professors Michael Porter and Robert Kaplan to engage directly in the latest thinking on value measurement. Armed with a common vocabulary and shared understanding, these leaders were able to reach consensus on a standard Saint Francis approach to not only defining value but also defining outcomes that matter, engaging patients, defining cost, mapping processes, and prioritizing value-oriented projects. We now have a clear mandate for value-driven design across the enterprise, with an aim to deliver value for patients, providers, and payers.

The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved.

While focusing on value is the key to staying ahead of the curve in an accountable care world, the advent of funding based on total cost of care and annual budgets requires a coherent geographic presence. In our very competitive marketplace, we have pursued a clinically integrated network approach to avoid the pitfalls and expense of vertical integration. Our alignment strategy is based on providing as much infrastructure support in as many areas as possible, short of an outright acquisition of the practices. By providing infrastructure support, credentialing, contracting, care coordination, and information technology—as well as requiring compliance with our clinical integration approach—we were able to develop our advanced Clinical Integrated Network.

Involving the Board and Engaging Physicians

As many population health initiatives and activities—even those focused on clinical aspects—are relatively new for most healthcare systems, it is absolutely critical to involve the board of directors and engage physicians as equal partners in the transition from volume to value. Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.

The outcome of that approach was that our board of directors endorsed the recommendation to position Saint Francis HealthCare Partners as the foundation for ACO development, again emphasizing the importance of what happens in physician offices and communities (i.e., not just the hospital). Numerous educational sessions were developed and deployed for the physician community. They were offered at several sites, and physicians were invited to attend at a site of their choice. Our initial aim was to answer as many questions as possible regarding the Affordable Care Act, ACO development, population health, physician requirements, patient engagement, and shared savings.

In terms of governance, we initially created ten ACO committees. More than 170 physicians signed up to participate, with most expressing interest in the Committee on Finance and Shared Savings. The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved. After two years in operation, the ACO committees were merged with the eight physician–hospital organization committees, as there was no need for them to operate in parallel universes.

Today, we have 12 committees, all meeting regularly and generating significant physician feedback. That said, we still have a significant knowledge gap. Although our providers have all received information on ACOs and population health management,

many express confusion or a desire to gain a more thorough understanding. Accordingly, we are working to develop the form and content of appropriately tailored population health education for our providers as well as for our patients and the community.

Accountable Care: Learning While Doing

Much like Zenty, Bieber, and Hammack, we have piloted several accountable care opportunities, all treated as disciplined experiments with the intent of refining our capabilities in preparation for assuming downside risk:

- *Employee ACO.* In an effort to both manage our own spending as a self-insured employer and create a model of what we could do for other large employers, we contracted with Saint Francis HealthCare Partners to create an employee ACO. The principles of accountable care were implemented for 6,500 members, and the combination of plan design changes, care coordination interventions, and wellness incentives yielded a tangible reduction in our cost trend experience.
- *Medicare Shared Savings Program ACO.* In January 2013, Saint Francis HealthCare Partners was awarded a Centers for Medicare & Medicaid Services (CMS) ACO contract covering 20,000 lives. As data from CMS has been fed into our claims data warehouse, we have developed new analytic competencies. In addition, we have embedded care coordinators in our large physician practices and used a public utility model to provide care coordination from a central source for our smaller practices.
- *Commercial ACOs.* Private payers quickly got up to speed with accountable care payment mechanisms. In the past year, Saint Francis HealthCare Partners entered into two commercial ACO arrangements, covering another 55,000 lives. Both of these commercial agreements have similar structures based on a total cost of care (i.e., population health management) model.
- *Bundles.* CJRI is a leading-edge program on a number of levels; for example, it offered one of the first bundled products for hip or knee replacement in the United States. These joint bundles include payment for surgeons, anesthesiologists, and the hospital. An additional postsurgical warranty rider is also available.
- *Care coordination.* Saint Francis employs a structured care coordination model, with staffing based on national norms. Covered lives are stratified by health risk, and health coaches are assigned to the highest-risk patients for interventions. Mechanisms to address gaps in care, transitions in care, ED follow-up, and discharge appointment follow-up are all part of the program.

Population Health (Not Just Healthcare)

Operating as a Medicare Shared Savings Program ACO, building an employee ACO, working with private payers to develop new commercial ACO arrangements, offering bundles to the marketplace, and ramping up an enterprise-wide care coordination program all depend on a population health management infrastructure that continues to require significant investment in personnel and information technology. We have successfully built such an infrastructure, but we know our work is not nearly done. A focus on clinical care and clinical integration is

insufficient as we move to an environment in which healthcare providers are accountable for broadly defined health outcomes. In other words, it's not just healthcare. In the context of population health, the big picture includes behavioral and social determinants of health. The key question is whether—and how—healthcare systems can influence these determinants or integrate community and social services that can.

In highlighting the total population health approach, Kindig and Isham also shed some light on why current approaches focus on clinical health for populations. They refer to the definition of population health used by the Institute of Medicine's Roundtable on Population Health Improvement: "The health outcomes of a group of individuals, including the distribution of such outcomes within the group." Given that scope, no one should be surprised or disappointed that healthcare organizations would focus on clinical care. Not only is it their expertise, but the emphasis on outcomes seems to support a clinical approach as well. However, clinical care improvement is only part of the original concept developed by Kindig and Stoddart (2003), which offers a broader and deeper view of population health as encompassing "the definition and measurement of health outcomes and their distribution, the patterns of determinants that influence such outcomes, and the policies that influence the optimal balance of determinants."

Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.

It is this expanded view that animates the total population health concept offered by Kindig and Isham. Indeed, perhaps most compelling in their article is the statement that "the contribution of healthcare to health is modest—only 20 percent—a fact that many healthcare leaders may find surprising." *Stunning* may be the better word choice here, particularly because other research suggests that 20 percent might be a generous estimate. The other 80 percent of healthcare determinants are identified as health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent)—items outside the control of traditional healthcare delivery systems. This finding challenges the paradigm that has tipped the balance toward sick care instead of healthcare.

That many of our patients struggle with behavioral and social determinants of health is not news. But what is the extent to which healthcare organizations can and should productively partner with patients, communities, and community-based support/social services organizations to address these determinants and improve outcomes? Different healthcare organizations will have different answers to this question. At Saint Francis, we have been working hard to engage all those partners when appropriate. (We say "when appropriate" because not all patients need social services. But for those who do, these services are the rate-limiting step for some patients. In other words, if people cannot take care of their lives, they will have a hard time taking care of their health.)

We have been learning real-world lessons for more than two years as our Emergency Medicine and Primary Care service lines work with our Innovation + Learning Center and Saint Francis HealthCare Partners to improve emergency medicine–primary care coordination. Much of this work has focused attention on the relatively small number of patients who account for a disproportionately large share of ED visits. We developed a robust ED registry that helped us move from

lamenting high *utilization* to getting to know our high *utilizers*. We are now making concerted efforts to integrate clinical services, to focus on care coordination—which includes coordinating the coordinators—and to partner with community and governmental organizations in building a network of care that historically would have been considered outside the purview of a hospital, much less healthcare in general. This is a step toward the community health business model promoted by Kindig and Isham.

Accountable Care Communities

Some of our efforts reflect a move toward an accountable care community (ACC) model that bridges clinical and community settings to address both the medical and the social needs of high-risk, high-cost, or vulnerable patients in an integrated manner consistent with the Triple Aim. In fact, we partnered with Community Solutions and the Department of Mental Health and Addiction Services in Connecticut—as well as with NuHealth, the Health and Welfare Council of Long Island (NY), and Health Leads on Long Island—to submit a proposal to CMS's Center for Medicare & Medicaid Innovation (CMMI) for developing ACCs in Hartford County and Nassau County.

Accountable care community is a term that was first employed by the Austen BioInnovation Institute in Akron (ABIA) to describe a multisector, community-based collaborative effort to transform healthcare in Northeast Ohio. The ABIA (2012) defines an ACC as

> *A collaborative, integrated, and measurable strategy that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services, and healthcare delivery. . . . It builds on initiatives to encompass not only the area's medical care providers, but also the public health system and community stakeholders whose work, taken together, spans the spectrum of the determinants of health.*

The National Governors Association (2013) suggests that ACCs "take the concept of medical homes and accountable care organizations one step further by fostering collaborations borne of shared responsibility among clinical and community sector participants to reform health systems in particular localities." Kindig and Isham mention ACCs as one model with the potential for addressing total population health.

The Integrator Role

Kindig and Isham appropriately highlight the importance of an "integrator," an organization that will pull together the various clinical and social services. Whether we like it or not, given our community presence, hospitals and healthcare organizations will be at the center of these population health dynamics. And even if we account for only 20 percent of health outcomes, we may always be expected by our communities and by business and government sectors to provide central leadership and do the population health "heavy lifting." That expectation will require that we play a role in both clinical and social initiatives. Finding the appropriate mix between the two will be a challenge for any provider. The HealthPartners example featured by Kindig and Isham and similar initiatives will be rare examples indeed unless and until payment models support this kind of work. But it is possible. As a point of reference, the actuarial analysis conducted for our CMMI proposal forecasted a reduction in Medicaid spending

that would produce shared savings sufficient to sustain the ACC program in both Hartford County and Nassau County.

The Hartford region has a highly competitive healthcare landscape, which raises another set of fundamental questions: Can total population health be achieved in a competitive clinical environment? Can the healthcare organizations work together? And how? Providers are in the midst of changing the clinical business model, but is it even more important to develop a sustainable model for integrating clinical services and social services to address the social determinants of health? As might be expected for any new endeavor, there are more questions than answers. But some answers are starting to emerge.

Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.

For instance, Saint Francis, along with the other major hospitals in Hartford, provided funding for the City of Hartford's *Community Health Needs Assessment* report. Scheduled for publication every three years, the first edition was released in March 2012 by the city's Department of Health and Human Services. This study examines the social determinants of health—income, shelter, education, access to nutritious foods, community norms, and cohesion—that affect the health of Hartford residents. The key will be to move from funding the documentation of needs to addressing them in a coherent and sustainable manner.

Conclusion

We may all agree that addressing the social determinants of health is the critical path toward "total population health" and, ultimately, health equity. But we must also acknowledge that moving from concept to real-world action will require significant start-up investment that cannot come from the providers alone. Achieving this complex transformation of care at the population level requires that we align our payment systems, our healthcare delivery systems, and our community support systems. Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.

Acknowledgments

The work ahead requires leaders to gather the collective minds of the thought leaders around us and together create the foundation to advance the delivery of healthcare. I would like to acknowledge the Saint Francis *Care* thought leaders who have contributed their expertise to this commentary: Gregory Makoul, PhD; Danyal Ibrahim, MD; Surendra Khera, MD; Adam Silverman, MD; Jess Kupec; and James Schepker.

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EXHIBIT 14 b

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
HEALTH PROGRESS

Today's Transformational Mission: Opportunity Abounds to Bring More People Better Care

September-October 2015
By: Richard J. Gilfillan, MD

Times of great change and uncertainty breed opportunity. Entrepreneurs create new ways to meet customer needs. Leaders of established organizations explore new ways of operating. One common solution to the challenge created by change is to partner with other organizations with capabilities that fit new marketplace demands.

American health care illustrates this phenomenon well today. Alternative care delivery and reimbursement models challenge us to discover new ways to deliver better outcomes. Exchange-based insurance products demand value networks at a time when we are just learning how to best measure quality and value. As a result, we are changing our business and clinical models without really knowing what care systems work best or how the outcomes will be evaluated. Amid all this change and uncertainty, it is no surprise that we have unprecedented levels of entrepreneurial startups, mergers, acquisitions and consolidations.

As with many other Catholic health systems, Trinity Health, based in Livonia, Michigan, believes that today's challenges are merely the entrance fee for taking on great opportunities to advance our mission. In fact, we believe there has never been a better time for Catholic health care to have a positive impact on our communities and the people we serve. These new models offer the opportunity for us to be rewarded for what our mission now calls us to do — provide excellent coordinated care to as many people as possible. This objective seems to be the natural evolution of the challenge our founders overcame as they spread across the country to provide direct acute patient care to individuals in need.

BUILT ON A BOLD FOUNDATION

The story of Trinity Health, as with most of Catholic health care, began more than 150 years ago when congregations of women and men religious answered the call to help heal and minister to people in need across the United States. These women and men traveled far and under tough conditions to serve others, especially vulnerable and marginalized populations. In the context of their times, these remarkable individuals built facilities and developed services from almost nothing, then continually looked at what they

could do next to help more people. Their efforts have resulted today in Catholic health care providing 16 percent of all hospital care in our country.

It is inspiring to ponder what called these women and men to be so outrageously bold. Clearly, they were driven by their commitment to service, to being a healing presence in the communities they served. In pursuit of their mission, they were willing to take risks, some of which probably seemed extreme. At times, they were torn between going slower and trying to do too much too soon. They chose to err on the side of moving forward assertively. They understood they could not linger until the right choices became obvious and that inaction carried risks of its own. In the face of great uncertainty, they moved boldly forward.

Today we are poised upon this foundation to build the health care system that our country needs for tomorrow. There are great uncertainties and risks associated with transforming our system, but we do not come from a legacy of excessive caution. That is why, at Trinity Health, we have framed a strategic transformation effort to build a people-centered health system — designed and operated to put the needs of people we serve at the center of all we do. We believe this strategy injects the bold intent of our founding congregations' missions into our work today.

Delivering people-centered care will require us to have many new operational capabilities. We will build some of these ourselves; others we will gain through partnerships with organizations that have more experience and skill. Across Catholic health care, we have seen many creative approaches to partnerships. Systems are collaborating with for-profits and not-for-profits, creating networks of nontraditional alliances and forming subsidiaries in areas such as research, insurance, telemedicine, home health, information technology and physician practice management.

MISSION IN ACTION

Our strategic plan, "People-Centered 2020," puts our mission into action and includes several key components. The first is to transform the way we deliver and are paid for providing care. To accomplish this, we have moved aggressively to develop new internal capabilities like our accountable care organization expertise. Although the Centers for Medicare and Medicaid Services' post-Affordable Care Act reimbursement playbook is still evolving, we have established Medicare Shared Savings ACOs in 18 of our 21 Regional Health Ministries. We have built out a set of new population health management activities that are essential for operating a successful ACO clinical and business model.

We also are participating broadly in the CMS Bundled Payments for Care Improvement program, with 53 facilities (38 hospitals, 12 continuing care facilities and three home health agencies) contracted for 40 different episodes of care as of Oct. 1, 2015. We are partnering with several different organizations that bring specific expertise in managing episode-based clinical models.

We also have partnered with other parties to build expanded provider networks. In Michigan, we partnered with Ascension to co-found Together Health Network, a physician-led, statewide, clinically integrated network of 25 hospitals and hundreds of ambulatory centers and physician offices. The network enables its member hospitals, physicians and other providers to jointly participate in the launch of new health plan products that give consumers greater choice and access to value-based health care services. Across our entire system, we have partnered with payers to establish 12 new value network products to date; with 18 more in development.

To develop the ability to manage full-risk capitation with payers, we established a joint venture, Trinity Health Partners, with Heritage Provider Network. Heritage has a 30-year history of successful contracting with insurers for full-risk capitation. This joint venture will develop care networks similar to ACOs, including primary care physicians, hospitals, clinics and other providers who join together to manage care for populations of patients. These networks will contract with insurers to assume full financial risk for managing these populations, which means they will be paid a set amount per patient and will be fully

responsible for covering any costs that exceed the payment. The Heritage relationship provides us with access to operational capabilities that have demonstrated success under capitation arrangements.

During the past year, we have formed a clinical care partnership with Walgreens to explore new possibilities provided by retail vendors. They will offer their stores in our facilities in select markets — enabling outpatient pharmacy services and expanded prescription and disease management programs to support people's health, while at the same time increasing consumers' access and lowering overall health care costs. We also are partnering with the Sharecare company to provide a digital consumer engagement platform. It provides a state-of-the-art, online environment that supports millions of people in their efforts to live healthier lives, and it helps them connect with physicians and remain personally engaged in their ongoing care.

Our plan also calls us to attempt to impact the transformation of our system nationally. That is why we joined with a group of Catholic health systems including Ascension, OSF Healthcare, Providence Health & Services, SLC Health and SSM Health, as well as other industry participants, to form the Health Care Transformation Task Force. Its goal is to bring together like-minded providers, payers, employers and patient advocacy groups to facilitate the path to transformation. Members include six of the nation's largest 15 health systems and four of the largest 25 health insurers. Together, we have committed to put 75 percent of our business into value-based arrangements that focus on better health, better care and lower costs by 2020. The task force has produced a number of policy recommendations, including several to CMS and the federal Department of Health and Human Services that we believe are helping to drive payment changes that support our transformation goals.

Our "People-Centered 2020" plan envisions significant growth in current communities, as well as expansion into new communities. Just as our founding congregations constantly reached out to new populations, we recognize that with the change and uncertainty in health care, there are significant opportunities to support existing Catholic health care ministries in communities that we do not serve today.

Our objective is not simply to be larger. It is to be an effective partner capable of bringing real value to regional Catholic health systems pursuing a similar mission. We believe we can provide significant economies of scale to some ministries, along with more sophisticated operational capabilities that allow them to continue their regional missions. These partnerships allow us to bring new ideas and competencies to smaller regional ministries faster. These are two-way partnerships. Within them, we share our knowledge and also learn from our new local ministries, identifying best practices that we can spread to other ministries in our system.

Our growth team, under Scott Nordlund, has developed a set of screening criteria to help us identify appropriate partners. These criteria look at a full range of operational dimensions, but start with an evaluation of mission alignment.

On July 1, 2015, St. Joseph's Health in Syracuse, New York, became a part of Trinity Health. (See story, page 18). This partnership extends our healing ministry to central New York, complementing our presence in Buffalo and Albany. We also signed a definitive agreement with Saint Francis Care, a health delivery system anchored in Hartford, Connecticut, to join Trinity Health. This merger expands our ability to work with community physicians and clinicians, providing better care coordination for people across New England, and extends Catholic care in the region.

RESPONSIBLE RISKS

Our strategy, of course, is not without risks. Our board and our leadership team often reflect on our legacy. They recognize that those who founded our organizations answered the call to help heal and minister to communities across the United States and faced far greater risks. They led the way, leaving a legacy of bold leadership for us to follow.

All health care organizations and leaders, not just those in Catholic health care, are living in this challenging environment of constant change and uncertainty. We all are struggling with the same issues of how far to move and how fast. Based on how we are working together in the task force, and what I hear as I talk with other health system leaders, I believe we are poised at a point where a transformation to a people-centered health system is possible. As leaders, we know that today's challenges offer us the once-in-a-lifetime opportunity to make our health care system right for our children and our country.

My hope is that, individually and collectively, we will seize this opportunity. We will need to be creative internally and externally, and that includes rethinking our approaches to operations and partnerships and always assessing our choices for alignment with our mission. As mission-driven organizations grounded in service to our communities, Catholic health systems are perfectly positioned to lead the way and build this new system of health care.

RICHARD J. GILFILLAN is president and CEO of Trinity Health, Livonia, Michigan.

EXHIBIT 15

Naugatuck Valley Women's Health Specialists

www.nvwhs.com

David Polke, MD
S. Mark Albini, MD
Irina Magidina, MD
Melanie B. Mund, MD
Deborah Garber, CNM

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

687 Straits Turnpike, Suite 2A • Middlebury, CT 06762
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I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

S. Mark Albini, M.D.

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ARTHUR J. O'NEILL
SIXTY-NINTH ASSEMBLY DISTRICT

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LAW REVISION COMMISSION

MEMBER
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JUDICIARY COMMITTEE
REGULATION REVIEW COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

October 22, 2015

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based

accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur J O'Neill

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

Franklin Medical GROUP

Rohit Beri, MD, FCCP

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

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Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

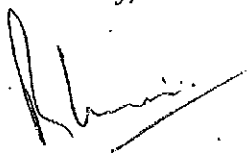
As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve

is approved, it will allow Saint Mary's physician's access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



Rohit Beri, MD, FCCP
Director, Medical ICU
St. Mary's Hospital
Waterbury, CT

Franklin Pulmonary Group *133 Scovill Street, Suite 104* *Waterbury, CT 06706*
Phone (203) 709-6244 *Fax (203) 709-3704*

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ANTHONY J. D'AMELIO
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HOUSE REPUBLICAN WHIP

MEMBER
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's is a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

Family Footcare, PC
James M. DeJesus, DPM, FACFAS
David W. Mader, DPM, FACFAS
Betty M. Carreira, DPM

November 11, 2015

Kimberly R. Martone
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77 Main St North · Suite 104 · Southbury, CT 06488 · Phone (203) 405-6501 · Fax (203) 405-6504

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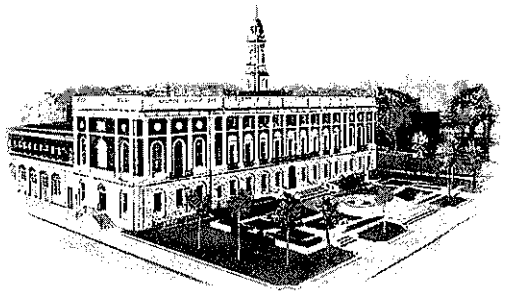

DEPARTMENT OF PUBLIC HEALTH

THE CITY OF WATERBURY

CONNECTICUT

October 26, 2015

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I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

William Quinn
Director of Public Health
Waterbury Health Department

NOSS
Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery
Michael E. Karnasiewicz, MD, ABNS
Neurosurgery & Spine Care
Jarob N. Mushaweh, MD, ABNS
Neurosurgery & Spine Care
Alan S. Waitze, MD, ABNS
Neurosurgery & Spine Care
John G. Strugar, MD
Neurosurgery & Spine Care
David L. Forshaw, MD
Neurosurgery & Spine Care
Judith L. Gorelick, MD, FAANS, FACS
Neurosurgery & Spine Care

Orthopaedics
Glenn G. Taylor, MD, ABOS
Orthopaedic Surgery & Spine Care
William F. Flynn, Jr., MD, ABOS
Joint Reconstruction & Sports Medicine
Frederick J. Watson, MD, ABOS
Orthopaedic Surgery & Sports Medicine

Pain Management
and Rehabilitation
Tamer B. Ghaly, MD
Interventional Pain Management
Thomas Mathew, MD
Interventional Physiatry
Alisa H. Darling, MD, ABPMR
Physical Medicine & Rehabilitation
Electrodiagnostic Medicine
Mark A. Mashia, DC, MS
Chiropractic Physician, Acupuncture

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System.

Main Office 500 Chase Parkway, Waterbury, CT 06708
Satellite Offices Shelton, CT - Southbury, CT - Torrington, CT
Phone (203) 755-NOSS (6677) (800) 463-8764
Fax Neurosurgery: (203) 573-9182 Orthopaedics: (203) 755-7166 Spine/physiatry: (203) 573-1272
Web www.nossmd.com

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

Saint Bridget Church

November 06, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, Connecticut 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

As a concerned citizen, and a local Pastor, I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful in this ever-changing and challenging environment. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

175 Main Street, Cheshire, Connecticut 06410
Phone 203-272-3531 • Fax 203-271-3356

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's Health System has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Jeffrey V. Romans

The Reverend Jeffrey V. Romans
Pastor

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

November 5, 2015

Ms. Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
P.O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

As a non-profit social service organization in Waterbury, it is very important to me who is in charge of operating the Hospital and its outpatient services. Saint Mary's has an outstanding reputation for its quality of patient care. I believe that Trinity, which now includes Saint Francis Care as one of its partners, will add to that quality, by leaving most of the Saint Mary's services as they are today, but with the financial resources to make existing services even better. Access to capital, as well as funding during the first five years after the acquisition, will make Saint Mary's stronger and more able to meet the needs of the community.

I strongly recommend you approve the application submitted by Saint Mary's and Trinity Health Corporation.

Respectfully submitted,

James M. O'Rourke
Chief Executive Officer

136 West Main Street, Waterbury, CT 06702 p: 203-754-YMCA f: 203-754-9095 www.waterburyymca.org

State of Connecticut

SENATE

SENATOR JOE MARKLEY
SIXTEENTH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
CAPITOL: (860) 240-0381
TOLL FREE: (800) 842-1421
E-MAIL: Joe.Markley@cga.ct.gov
WEBSITE: www.SenatorMarkley.com

ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN

RANKING MEMBER
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

Franklin Medical
GROUP PC

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint

Kimberly R. Martone
Office of health Care Access
November 12, 2015

Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Paul Kelly, MD
Chief of Cardiology

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE LEZLYE ZUPKUS
EIGHTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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FAX: (860) 240-0207
Lezlye.Zupkus@housegop.ct.gov

RANKING MEMBER
PUBLIC SAFETY AND SECURITY COMMITTEE

MEMBER
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

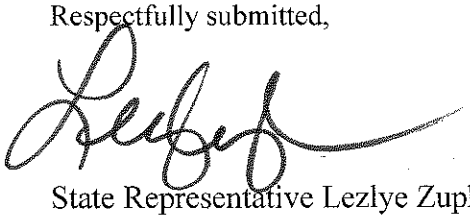
The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

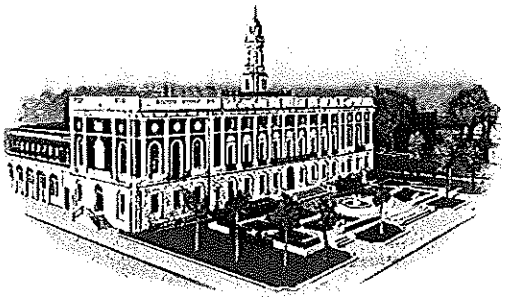
Respectfully submitted,



State Representative Lezlye Zupkus

NEIL M. O'LEARY
MAYOR

JOSEPH A. GEARY
CHIEF OF STAFF



OFFICE OF THE MAYOR
THE CITY OF WATERBURY
CONNECTICUT

October 21, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

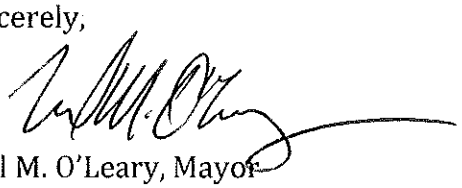
I am writing in support of Saint Mary's application to become part of the Trinity Health Corporation. This acquisition by Trinity will allow Saint Mary's to become affiliated with Saint Francis Care in Hartford as well as Trinity. Saint Francis and Saint Mary's will become part of a Regional Health Ministry in Connecticut (NE-RHM) that will include hospitals and health systems in western Massachusetts as well. By joining Trinity's network of over 86 hospitals in the country, Saint Mary's will have access to a vast range of services and initiatives such as clinical quality initiatives, information technology and supply chain initiatives as well as the financial support that comes as part of a larger network. Financial support is critical in order to meet higher health expectations that have developed in the past few years. Saint Mary's is an outstanding community hospital serving the people of this City, and it needs support from a larger network to continue to provide the same excellent care to a growing number of people.

The demands of the new healthcare laws and the expense of operating a large hospital in downtown Waterbury and a system with 18 service towns will put enormous pressure on Saint Mary's in the future. Trinity is capable of helping Saint Mary's continue to provide exceptional care to the people of Waterbury and the greater Waterbury community. Saint Mary's carefully considered other alternatives,

but found that Trinity had the philosophy and commitment to the same core values that Saint Mary's has maintained for over one hundred years. Top among these values are fulfilling the community-based mission, delivering quality care and adhering to the Ethical and Religious Directives that are part of Saint Mary's Catholic identity.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc. and the Regional Health Ministry formed in CT by Trinity Health Corporation and Saint Francis Care, Inc.

Sincerely,



Neil M. O'Leary, Mayor

SS. Peter & Paul Church

67 Southmayd Road

Waterbury, CT 06705

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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Kimberly R. Martone
CT DPH Office of Health Care Access
[Date]

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

[Name]

Saint Mary's
HOSPITAL

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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Saint Mary's
HOSPITAL

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Philip R Corvo MD MA FACS.

Philip R Corvo MD MA FACS
Chairman, Department of Surgery
Director, Surgical Critical Care
Stanley J Dudrick Department of Surgery
Institutional Official
Saint Mary's Hospital, Waterbury, Connecticut
Governor-At-Large, American College of Surgeons
Past President, Connecticut Chapter of the American College of Surgeons
Past Health Commissioner, City of Stamford

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ANTHONY J. D'AMELIO
SEVENTY-FIRST ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

TOLL FREE: (800) 842-1423
FAX: (860) 240-0207
Anthony.DAmelio@housegop.ct.gov

HOUSE REPUBLICAN WHIP

MEMBER
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

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I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ARTHUR J. O'NEILL
SIXTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
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HARTFORD, CT 06106-1591

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TOLL FREE: (800) 842-1423
FAX: (860) 240-0207
Arthur.ONeill@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

CHAIRMAN
LAW REVISION COMMISSION

MEMBER
APPROPRIATIONS COMMITTEE
JUDICIARY COMMITTEE
REGULATION REVIEW COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

October 22, 2015

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CRAIG A. MINER
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
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Craig.Miner@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
State Representative
66th District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE DAVID K. LABRIOLA
ONE HUNDRED THIRTY-FIRST ASSEMBLY DISTRICT

185 RIGGS STREET
OXFORD, CONNECTICUT 06478
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FAX: 860-240-0207
David.Labriola@housegop.ct.gov

HOUSE REPUBLICAN WHIP

MEMBER
TRANSPORTATION COMMITTEE
GOVERNMENT ADMINISTRATION AND ELECTIONS COMMITTEE
JUDICIARY COMMITTEE

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

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We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Dave

David Labriola
State Representative
131st District
Naugatuck and Oxford

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

Representative David Zoni
81st Assembly District
Southington

Legislative Office Building
Hartford, Connecticut 06106
860-240-8585 or 800-842-8267
David.Zoni@cga.ct.gov

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

State Representative David Zoni
81st District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ERIC C. BERTHEL
SIXTY-EIGHTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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MEMBER
EDUCATION COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
PUBLIC HEALTH COMMITTEE

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Eric C. Berthel
State Representative – 68th District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE LEZLYE ZUPKUS
EIGHTY-NINTH ASSEMBLY DISTRICT

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RANKING MEMBER
PUBLIC SAFETY AND SECURITY COMMITTEE

MEMBER
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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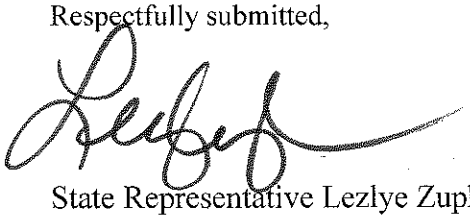
Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,



State Representative Lezlye Zupkus

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE SELIM G. NOUJAIM
SEVENTY FOURTH ASSEMBLY DISTRICT

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WATERBURY, CT 06705

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Selim.Noujaim@housegop.ct.gov

HOUSE REPUBLICAN WHIP

CHAIRMAN
REGULATIONS REVIEW COMMITTEE

MEMBER
COMMERCE COMMITTEE
EXECUTIVE AND LEGISLATIVE NOMINATIONS
INTERNSHIP COMMITTEE

Date: October 23, 2015

Ms. Kimberly R. Martone, Director of Operations

CT Department of Public Health

Office of Health Care Access

410 Capitol Avenue PO Box 340308

Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System

and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully,

Selim G. Noujaim

Selim G. Noujaim

Saint Mary's
HOSPITAL

Department of Dentistry

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area.

Kimberly R. Martone
Office of Health Care Access
November 11, 2015

Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Richard Putnam, D.M.D., F.A.G.D.
Chief, Department of Dentistry
Director, GPR Program
Saint Mary's Hospital
133 Scovill Street
Waterbury, CT 06706
203-709-7055 - phone
203-709-7750 -fax
richard.putnam@stmh.org

Waterbury ORTHOPAEDIC ASSOCIATES, PC

ERIC J. OLSON, M.D.
DENNIS M. RODIN, M.D.
MICHELLE MARIANI, M.D.

ALAN HOULE, PA-C
PAM NOLE, ADMINISTRATOR

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

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1211 West Main Street
Waterbury, CT 06708-3178
Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

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Sincerely,

Dennis Rodin, MD

1211 West Main Street
Waterbury, CT 06708-3178
Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

Main St. Waterbury

Culture Education Business

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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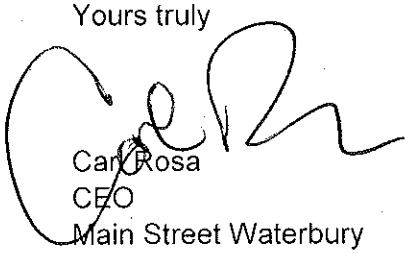
I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Yours truly



Carl Rosa
CEO
Main Street Waterbury

CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C.

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY
HEARING, BALANCE DISORDERS & FALL PREVENTION CENTER

Neil F. Schiff, M.D.
Mahesh H. Bhaya, M.D.
Board Certified in Otolaryngology

Deborah A. Mastriani, APRN

Dana K. Cipriano
Practice Administrator

Specializing in all aspects of:
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Speech & Swallow Evaluation
Voice Evaluation & Management
Laser Surgery
Allergy Testing & Treatment
Apnea and Snoring Procedures
Hearing Evaluation
Hearing Aid Dispensing
Balance Disorders & Fall Prevention

One Exchange Place
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Fax (203) 264-2920

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Southington, CT 06489
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Fax (860) 276-0828

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November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

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I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely yours,

NF Schiff MD

Neil F. Schiff, M.D.
President, CT ENT
Fellow AAO/HNS

State of Connecticut

SENATE

SENATOR JOE MARKLEY
SIXTEENTH DISTRICT

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WEBSITE: www.SenatorMarkley.com

ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN

RANKING MEMBER
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

State of Connecticut
SENATE

SENATOR ROBERT J. KANE
THIRTY-SECOND DISTRICT

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WEBSITE: www.SenatorKane.com

DEPUTY MINORITY LEADER PRO TEMPORE &
CAUCUS CHAIRMAN FOR POLICY

RANKING MEMBER
APPROPRIATIONS COMMITTEE
EXECUTIVE & LEGISLATIVE NOMINATIONS COMMITTEE

MEMBER
PUBLIC HEALTH COMMITTEE

10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Senator Rob Kane – 32nd District

Saint Mary's
HOSPITAL

11/12/15

Michael Simms III, MD, ABIM (ID)
Infectious Diseases
56 Franklins St.
Waterbury, CT 06706
203-709-6402

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

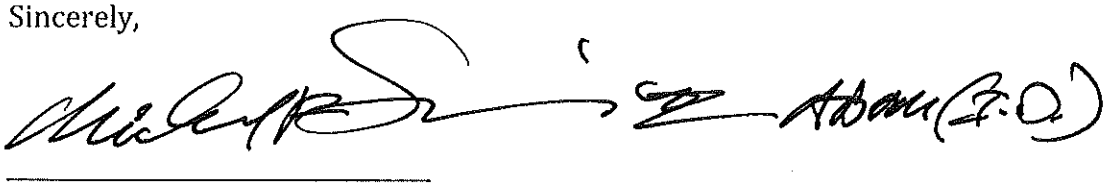
As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint

Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



Waterbury Regional Chamber
driving business to business

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired by Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a nonprofit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health, as well as Saint Francis Care and Saint Mary's, are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and standalone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. Saint Mary's merger with Saint Francis Care, together with their ultimate acquisition by Trinity Health, will give both Catholic hospitals the support needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

Waterbury Regional Chamber
driving business to business

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

We have known for a long time that Saint Mary's was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options for a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Lynn G. Ward

Lynn G. Ward
President & CEO
Waterbury Regional Chamber
83 Bank St., Fourth Floor
Waterbury, CT 06721
203-757-0701, Ext. 310
lward@waterburychamber.com

ABDULMASIH ZARIF, M.D., LLC
BOARD CERTIFIED
GENERAL, LAPAROSCOPIC AND CANCER SURGERY

November, 06, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

RE: Certificate of Need Application seeking approval for Saint Mary's Health system and its subsidiaries to be acquired as part of trinity health corporation.

Dear Ms.Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

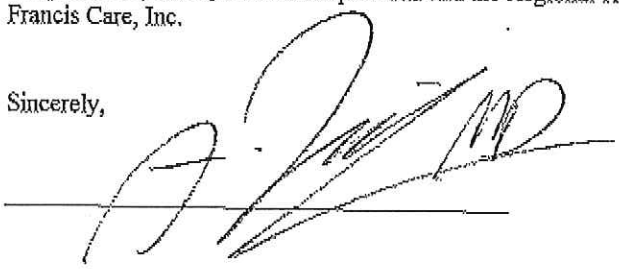
Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make to Saint Mary's over five years will, in part, be used for the community health/population management initiatives, physician network and development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality of care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health" an alliance with Yale New Haven Health System.

I recognize thew challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that the health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with the resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



1389 West Main Street • Tower 2 - Room 321 • Waterbury, CT 06708 • (203) 757-1113 • Fax (203) 575-9018

EXHIBIT 16

EXHIBIT
List of Residencies

The following is a list of residencies offered at Saint Francis through the University of Connecticut School of Medicine:

* Anesthesiology
* Emergency Medicine
* Family Medicine
* Pediatrics
* Internal Medicine (General)
* Internal Medicine (Cardiology)
* Internal Medicine (Endocrinology)
* Internal Medicine (Gastroenterology)
* Internal Medicine (Hematology/Oncology)
* Internal Medicine (Infectious Disease)
* Internal Medicine (Pulmonary/ Critical Care)
* Maternal Fetal Medicine
* Nuclear Medicine
* Orthopedic Surgery
* Otolaryngology
* Psychiatry
* Radiology
* Surgery
* Urology
* Geriatric Medicine
* Nephrology
* Primary Care Medicine

The following are the Saint Francis Residency and Fellowship programs:

* General Dentistry Residency
* Obstetrics and Gynecology Residency
* Podiatric Medicine and Surgery Residency
* Colon/Rectal Surgery Fellowship

EXHIBIT 17

Exhibit 17

Financial Worksheets

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

Financial Worksheets including actual and projected results have been prepared for both consolidated Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital (only). FY 2015 actual results are preliminary unaudited results.

General Assumptions:

- For all years, the Hospital Tax has been reclassified as an "Other Deductions" line A.4 to be consistent with Trinity Health - New England for presentation purposes.
- FY 2015 actual results include a $2.9 million receivable from the State of Connecticut for the 1st quarter supplemental payment associated with the Hospital Provider Tax for the State's FY 2016. If the State further reduces funding, actual results may differ. This amount is included in "Other Deductions", Line A.4.
- The FY 2016 revised budget includes the assumption that the State will resume the supplemental payments in the 4th quarter of FY 2016 (or 1st quarter of State FY 2017) of $2.9 million.
- As a result of the decrease in State supplemental payments, the FY 2016 budget was revised and includes the following:
    - A net increase of 117 full-time equivalents was reduced to 74 as a result of delayed hiring for open positions. In addition, the wage increase for FY 2016 was reduced to 2%,
    - Related employee benefits were also decreased approximately 3%, and
    - Other cost reduction initiatives approximating $2.3 million.
- FY 2017-2019 assumes the State Provider Tax will remain at the same level as included in the FY 2016 revised budget.

The following summarizes key assumptions used in projecting the FY 2017 - 2019 operating results:

- Inpatient volume is projected to decrease .5% each year, respectively, from FY 2017 through FY 2019 as utilization of inpatient services shifts as a result of population health management.
- Outpatient visits is projected to increase 2% each year, respectively, from FY 2017 through FY 2019 as preventive care increases as a result of population health management.
- An increase in Medicare reimbursement is included in FYs 2017-2019 as a result of a change in the Medicare wage index.
- Bad debts as a percentage of gross revenues are expected to remain flat.
- Projected salary and benefits expense includes increases of 2.5% for FY 2017 through FY 2019. While overall FTE's remain flat, the increase represents employee merit/inflation increases.

- Supplies and other expenses include inflation increases between 2%-5% for FY2017 through FY 2019.
- The existing CHEFA debt was refinanced in 2015, resulting in a reduction in Interest Expense in FY 2016-2019, Operating Expenses - Line 7.

Based on Trinity Health's historical success with the integration of hospitals and health systems into the Trinity Health system, it is expected that operational savings of approximately 1% of current annual operating expenses or $3.1 million will be realized. The incremental projected amounts are included in the financial worksheets beginning in FY 2017, realizing 50%, as we anticipate a closing on or around July 1, 2016. In FY 2018, we anticipate realizing the full 1%. Some areas where we expect to recognize these opportunities include purchased services, supply chain, insurance and risk management, treasury, tax and compliance. These reductions have been included in the financial worksheets in Lines 4 Supplies and Drugs and Line 10 Other Operating Expenses.

There are no planned changes to the clinical services offered by SMHS as a result of this transaction; however, as part of its population health and other health reform initiatives, the parties may, in the future, choose to make changes in the services offered by Trinity Health - New England or its subsidiaries that are intended to best meet the communities health care needs.

In addition to the expected operational savings noted above, the known significant financial benefits to SMHS are as follows:

- As previously noted on page 15 of the CON application, a commitment by Trinity Health to ensure investment of $100 million dollars (potentially up to $120 million) in capital that will allow SMHS to:
    - Address equipment replacement and routine facility upgrades that have been delayed due to the recent reductions in state and federal healthcare funding; and
    - Make additional strategic investments in healthcare initiatives as opportunities arise over the next 5 years, including those necessary to move towards risk-based contracting.

    Refer to page 72-73 of the CON application for approximate allocation of capital spending and needs.

- Ability to access capital financing at favorable rates through Trinity Health - New England via Trinity Health's intercompany loan program.
- Support to enable SMHS to adequately fund its pension obligations.
- Access to Trinity Health - New England and Trinity Health system services to promote efficient and effective care delivery.

Note: The impact of the financial commitment by Trinity Health of $100 million (potentially up to $120 million) has not been included in the projections because the allocation of these funds has not yet occurred.

If any proposed investment requires additional regulatory approval, this approval will be obtained prior to the investment being made.

NON-PROFIT

Saint Mary's Health System, Inc.

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$832,217	$873,828		$873,828	$917,519		$917,519	$963,395		$963,395	$1,011,565		$1,011,565
2	Less: Allowances	$535,300	$558,162		$558,162	$592,210		$592,210	$628,335		$628,335	$666,663		$666,663
3	Less: Charity Care	$1,854	$2,500		$2,500	$2,625		$2,625	$2,756		$2,756	$2,894		$2,894
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	**$290,831**	**$303,420**	**$0**	**$303,420**	**$312,938**	**$0**	**$312,938**	**$322,558**	**$0**	**$322,558**	**$332,262**	**$0**	**$332,262**
5	Medicare	$115,320	$124,657		$124,657	$127,442		$127,442	$130,173		$130,173	$132,837		$132,837
6	Medicaid	$55,779	$51,255		$51,255	$51,391		$51,391	$51,470		$51,470	$51,492		$51,492
7	CHAMPUS & TriCare	$257	$264		$264	$268		$268	$271		$271	$274		$274
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$171,356**	**$176,176**	**$0**	**$176,176**	**$179,101**	**$0**	**$179,101**	**$181,914**	**$0**	**$181,914**	**$184,603**	**$0**	**$184,603**
9	Commercial Insurers	$108,375	$115,495		$115,495	$121,554		$121,554	$127,811		$127,811	$134,262		$134,262
10	Uninsured	$709	$727		$727	$736		$736	$744		$744	$751		$751
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$9,139	$9,739		$9,739	$10,250		$10,250	$10,778		$10,778	$11,322		$11,322
13	Other	$1,252	$1,283		$1,283	$1,297		$1,297	$1,311		$1,311	$1,324		$1,324
	Total Non-Government	**$119,475**	**$127,244**	**$0**	**$127,244**	**$133,837**	**$0**	**$133,837**	**$140,644**	**$0**	**$140,644**	**$147,659**	**$0**	**$147,659**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$290,831**	**$303,420**	**$0**	**$303,420**	**$312,938**	**$0**	**$312,938**	**$322,558**	**$0**	**$322,558**	**$332,262**	**$0**	**$332,262**
14	Less: Provision for Bad Debts	$9,675	$9,990		**$9,990**	$10,490		**$10,490**	$11,014		**$11,014**	$11,565		**$11,565**
	Net Patient Service Revenue less provision for bad debts	**$281,156**	**$293,430**	**$0**	**$293,430**	**$302,449**	**$0**	**$302,449**	**$311,544**	**$0**	**$311,544**	**$320,697**	**$0**	**$320,697**
15	Other Operating Revenue	$8,248	$7,253		**$7,253**	$7,253		**$7,253**	$7,253		**$7,253**	$7,253		**$7,253**
17	Net Assets Released from Restrictions	$733	$733		**$733**	$733		**$733**	$733		**$733**	$733		**$733**
	TOTAL OPERATING REVENUE	**$290,137**	**$301,416**	**$0**	**$301,416**	**$310,435**	**$0**	**$310,435**	**$319,530**	**$0**	**$319,530**	**$328,683**	**$0**	**$328,683**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$123,041	$132,928		$132,928	$136,251		$136,251	$139,657		$139,657	$143,149		$143,149
2	Fringe Benefits	$32,244	$30,602		$30,602	$31,367		$31,367	$32,151		$32,151	$32,955		$32,955
3	Physicians Fees	$9,915	$11,031		$11,031	$11,362		$11,362	$11,703		$11,703	$12,054		$12,054
4	Supplies and Drugs	$47,026	$48,991		$48,991	$51,441	($720)	$50,720	$54,013	($1,512)	$52,500	$56,713	($1,588)	$55,125
5	Depreciation and Amortization	$11,502	$11,713		$11,713	$12,064		$12,064	$12,426		$12,426	$12,799		$12,799
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$979	$231		$231	$219		$219	$208		$208	$198		$198
8	Malpractice Insurance Cost	$5,572	$5,917		$5,917	$6,035		$6,035	$6,156		$6,156	$6,279		$6,279
9	Lease Expense				$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,631	$55,648		$55,648	$56,761	($817)	$55,944	$57,896	($1,621)	$56,275	$59,054	($1,654)	$57,401
	TOTAL OPERATING EXPENSES	**$287,910**	**$297,061**	**$0**	**$297,061**	**$305,501**	**($1,538)**	**$303,963**	**$314,211**	**($3,133)**	**$311,078**	**$323,201**	**($3,241)**	**$319,960**
	INCOME/(LOSS) FROM OPERATIONS	**$2,227**	**$4,355**	**$0**	**$4,355**	**$4,934**	**$1,538**	**$6,472**	**$5,319**	**$3,133**	**$8,453**	**$5,482**	**$3,241**	**$8,723**
	NON-OPERATING REVENUE	**$2,190**	**$2,877**		**$2,877**	**$2,963**		**$2,963**	**$3,052**		**$3,052**	**$3,144**		**$3,144**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$4,417**	**$7,232**	**$0**	**$7,232**	**$7,897**	**$1,538**	**$9,435**	**$8,371**	**$3,133**	**$11,505**	**$8,625**	**$3,241**	**$11,867**
	Principal Payments	**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**

NON-PROFIT

Saint Mary's Health System, Inc.

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.8%**	**1.4%**	**0.0%**	**1.4%**	**1.6%**	**0.0%**	**2.1%**	**1.6%**	**0.0%**	**2.6%**	**1.7%**	**0.0%**	**2.6%**
2	Hospital Non Operating Margin	**0.7%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**
3	Hospital Total Margin	**1.5%**	**2.4%**	**0.0%**	**2.4%**	**2.5%**	**0.0%**	**3.0%**	**2.6%**	**0.0%**	**3.6%**	**2.6%**	**0.0%**	**3.6%**
D.	**FTEs**	**1,680**	1,754		**1,754**	1,754		**1,754**	1,754		**1,754**	1,754		**1,754**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	11,847	11,875		**11,875**	11,816		**11,816**	11,757		**11,757**	11,698		**11,698**
2	Outpatient Visits	238,522	246,611		**246,611**	251,543		**251,543**	256,574		**256,574**	261,706		**261,706**
	TOTAL VOLUME	**250,369**	**258,486**	**0**	**258,486**	**263,359**	**0**	**263,359**	**268,331**	**0**	**268,331**	**273,404**	**0**	**273,404**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity: / Description	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$746,752	$786,099		$786,099	$825,404		$825,404	$866,674		$866,674	$910,008		$910,008
2	Less: Allowances	$484,798	$513,815		$513,815	$545,158		$545,158	$578,412		$578,412	$613,695		$613,695
3	Less: Charity Care	$1,854	$1,947		$1,947	$2,044		$2,044	$2,146		$2,146	$2,254		$2,254
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	**$255,868**	**$260,591**	**$0**	**$260,591**	**$268,456**	**$0**	**$268,456**	**$276,370**	**$0**	**$276,370**	**$284,313**	**$0**	**$284,313**
5	Medicare	$101,452	$107,051		$107,051	$110,282		$110,282	$113,533		$113,533	$116,796		$116,796
6	Medicaid	$49,075	$44,014		$44,014	$45,342		$45,342	$46,679		$46,679	$48,020		$48,020
7	CHAMPUS & TriCare	$205	$208		$208	$215		$215	$221		$221	$227		$227
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$150,732**	**$151,273**	**$0**	**$151,273**	**$155,839**	**$0**	**$155,839**	**$160,433**	**$0**	**$160,433**	**$165,044**	**$0**	**$165,044**
9	Commercial Insurers	$95,439	$99,181		$99,181	$102,174		$102,174	$105,186		$105,186	$108,209		$108,209
10	Uninsured	$614	$599		$599	$617		$617	$636		$636	$654		$654
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,034	$8,339		$8,339	$8,591		$8,591	$8,844		$8,844	$9,098		$9,098
13	Other	$1,049	$1,199		$1,199	$1,235		$1,235	$1,271		$1,271	$1,308		$1,308
	Total Non-Government	**$105,136**	**$109,318**	**$0**	**$109,318**	**$112,617**	**$0**	**$112,617**	**$115,937**	**$0**	**$115,937**	**$119,269**	**$0**	**$119,269**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$255,868**	**$260,591**	**$0**	**$260,591**	**$268,456**	**$0**	**$268,456**	**$276,370**	**$0**	**$276,370**	**$284,313**	**$0**	**$284,313**
14	Less: Provision for Bad Debts	$8,180	$8,512		**$8,512**	$8,938		**$8,938**	$9,384		**$9,384**	$9,854		**$9,854**
	Net Patient Service Revenue less provision for bad debts	**$247,688**	**$252,079**	**$0**	**$252,079**	**$259,519**	**$0**	**$259,519**	**$266,985**	**$0**	**$266,985**	**$274,459**	**$0**	**$274,459**
15	Other Operating Revenue	$7,473	$6,267		**$6,267**	$6,267		**$6,267**	$6,267		**$6,267**	$6,267		**$6,267**
17	Net Assets Released from Restrictions	$733	$700		**$700**	$700		**$700**	$700		**$700**	$700		**$700**
	TOTAL OPERATING REVENUE	**$255,894**	**$259,046**	**$0**	**$259,046**	**$266,486**	**$0**	**$266,486**	**$273,952**	**$0**	**$273,952**	**$281,426**	**$0**	**$281,426**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$88,793	$93,086		$93,086	$95,413		$95,413	$97,798		$97,798	$100,243		$100,243
2	Fringe Benefits	$27,562	$25,721		$25,721	$26,364		$26,364	$27,023		$27,023	$27,699		$27,699
3	Physicians Fees	$10,621	$11,268		$11,268	$11,606		$11,606	$11,954		$11,954	$12,313		$12,313
4	Supplies and Drugs	$45,059	$44,320		$44,320	$46,536	($652)	$45,884	$48,863	($1,368)	$47,495	$51,306	($1,437)	$49,869
5	Depreciation and Amortization	$10,805	$11,116		$11,116	$11,449		$11,449	$11,793		$11,793	$12,147		$12,147
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$963	$216		$216	$205		$205	$195		$195	$185		$185
8	Malpractice Insurance Cost	$5,350	$5,094		$5,094	$5,196		$5,196	$5,300		$5,300	$5,406		$5,406
9	Lease Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$48,175		$48,175	$49,139	($708)	$48,431	$50,121	($1,403)	$48,718	$51,124	($1,431)	$49,692
	TOTAL OPERATING EXPENSES	**$238,198**	**$238,996**	**$0**	**$238,996**	**$245,908**	**($1,359)**	**$244,549**	**$253,048**	**($2,772)**	**$250,276**	**$260,422**	**($2,868)**	**$257,554**
	INCOME/(LOSS) FROM OPERATIONS	**$17,696**	**$20,050**	**$0**	**$20,050**	**$20,577**	**$1,359**	**$21,936**	**$20,904**	**$2,772**	**$23,676**	**$21,004**	**$2,868**	**$23,872**
	NON-OPERATING REVENUE	**$3,158**	**$3,716**		**$3,716**	**$3,827**		**$3,827**	**$3,942**		**$3,942**	**$4,061**		**$4,061**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$20,854**	**$23,766**	**$0**	**$23,766**	**$24,405**	**$1,359**	**$25,764**	**$24,847**	**$2,772**	**$27,618**	**$25,064**	**$2,868**	**$27,932**
	Principal Payments	**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**6.8%**	**7.6%**	**0.0%**	**7.6%**	**7.6%**	**0.0%**	**8.1%**	**7.5%**	**0.0%**	**8.5%**	**7.4%**	**0.0%**	**8.4%**
2	Hospital Non Operating Margin	**1.2%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**
3	Hospital Total Margin	**8.1%**	**9.0%**	**0.0%**	**9.0%**	**9.0%**	**0.0%**	**9.5%**	**8.9%**	**0.0%**	**9.9%**	**8.8%**	**0.0%**	**9.8%**
D.	**FTEs**	**1,384**	**1,415**		**1,415**	1,415		**1,415**	1,415		**1,415**	1,415		**1,415**
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	11,847	11,875		**11,875**	11,816		**11,816**	11,757		**11,757**	11,698		**11,698**
2	Outpatient Visits	238,522	246,611		**246,611**	251,543		**251,543**	256,574		**256,574**	261,706		**261,706**
	TOTAL VOLUME	**250,369**	**258,486**	**0**	**258,486**	**263,359**	**0**	**263,359**	**268,331**	**0**	**268,331**	**273,404**	**0**	**273,404**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

SAINT MARY'S HEALTH SYSTEM, INC
($ in thousands)

		Month		Year to Date	
		Sept 2015	Prior Year	Sept 2015	Prior Year
A.	**Operating Performance**				
	Operating Margin	-0.1%	10.0%	0.8%	3.2%
	Non-Operating Margin	-5.0%	4.8%	0.7%	1.4%
	Total Margin	-5.0%	14.9%	1.5%	4.6%
	Bad Debt as % of Gross Revenue	0.7%	1.3%	1.2%	1.5%
B.	**Liquidity**				
	Current Ratio	1.80	2.21	1.80	2.21
	Days Cash on Hand	19	34	19	34
	Days in Net Accounts Receivable	41.72	41.11	41.72	41.11
	Average Payment Period	58	60	58	60
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.29	0.41	0.29	0.41
	Long-term Debt to Capitalization	0.23	0.29	0.23	0.29
	Unrestricted Cash to Debt	1.02	1.26	1.02	1.26
	Times Interest Earned Ratio	-57.7	35.3	5.50	9.94
	Debt Service Coverage Ratio	4.9	15.0	4.90	6.92
	Equity Financing Ratio	4.31	4.42	4.31	4.42
D.	**Additional Statistics**				
	Income from Operations	$ (3)	$ 2,618	$ 2,227	$ 9,146
	Revenue Over/(Under) Expense	$ (1,137)	$ 3,879	$ 4,417	$ 12,830
	EBITDA	$ 1,240	$ 3,756	$ 14,709	$ 21,113
	Patient Cash Collected	$ 21,477	$ 20,756	$ 272,841	$ 258,462
	Cash and Cash Equivalents	$ 14,907	$ 26,867	$ 14,907	$ 26,867
	Net Working Capital	$ 17,591	$ 29,580	$ 17,591	$ 29,580
	Unrestricted Assets	$ 30,950	$ 32,895	$ 30,950	$ 32,895
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Saint Mary's Hospital (Hospital only)	Month		Year to Date	
	Sept 2015	Prior Year	Sept 2015	Prior Year
A. Operating Performance				
Operating Margin	9.0%	15.0%	6.8%	8.2%
Non-Operating Margin	-6.0%	6.0%	1.2%	2.0%
Total Margin	3.0%	21.0%	8.0%	10.2%
Bad Debt as % of Gross Revenue	0.4%	1.1%	1.1%	1.5%
B. Liquidity				
Current Ratio	1.62	2.11	1.62	2.11
Days Cash on Hand	23	40	23	40
Days in Net Accounts Receivable	41.36	41.00	41.36	41.00
Average Payment Period	61	64	61	64
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.32	0.43	0.32	0.43
Long-term Debt to Capitalization	0.24	0.30	0.24	0.30
Unrestricted Cash to Debt	0.97	1.24	0.97	1.24
Times Interest Earned Ratio	30.5	44.9	22.65	18.96
Debt Service Coverage Ratio	11.3	18.0	9.82	10.50
Equity Financing Ratio	4.23	4.00	4.23	4.00
D. Additional Statistics				
Income from Operations	$ 1,820,855	$ 3,421,482	$ 17,685,330	$ 20,208,092
Revenue Over/(Under) Expense	$ 600,798	$ 4,796,952	$ 20,843,189	$ 25,224,814
EBITDA	$ 2,835,133	$ 4,497,195	$ 29,452,841	$ 31,500,487
Patient Cash Collected	$ 18,920,140	$ 17,720,977	$ 239,372,362	$ 229,104,209
Cash and Cash Equivalents	$ 13,310,208	$ 24,610,432	$ 13,310,208	$ 24,610,432
Net Working Capital	$ 7,910,369	$ 21,049,393	$ 7,910,369	$ 21,049,393
Unrestricted Assets	$ 25,882,585	$ 27,668,208	$ 25,882,585	$ 27,668,208
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Exhibit 17
Financial Worksheets

The key assumptions used in Trinity Health- New England, Inc. financial worksheets include the following:

- FY 2015 amounts represent unaudited financial results as of September 30, 2105
- FY 2016 is Trinity Health – New England's revised budget which includes cost reductions as a result of the reduction in the State's supplemental payments.
- Inpatient volume for FY 2016 is projected to be flat with slight decreases in volume in 2017, 2018 and 2019 as a result of decreased utilization of inpatient services as we shift to population health. This overall projected decrease is offset by a slight increase in utilization in the Connecticut Joint Replacement Service line.
- Slight growth in hospital outpatient visits is expected and the projections include increases of .1%, .1% and .2% respectively in 2016 through 2019.
- The projected amounts include an expectation that Saint Francis *Care* will begin to assume risk contracts in FY 2016 and receive per member per month payments to cover the healthcare costs.
- Projected salary expenses include increases of 3.7%, 1.1%, 2.3% and 3.5%, respectively, in 2016 through 2019. This projection anticipates an increase in the number of employees as well as an inflation increase.
- Supplies and other expenses remain flat in FY 2016 and 2017 and slight increases are expected in 2018 and 2019.
- Decrease in interest expense is the result of the restructure of outstanding debt as of October 1 to an intercompany loan with Trinity Health.

The financial projections for FY 2016-2019 do not include potential synergies to be realized as a result of the recent approved transaction between Trinity Health and Trinity Health-New England effective October 1, 2015.

Applicant: Trinity Health - New England, Inc. **NON-PROFIT**

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$ 2,433,797	$ 2,577,924	$ 224,093	$ 2,802,017	$ 2,796,713	$ 917,519	$ 3,714,232	$ 2,992,483	$ 963,395	$ 3,955,878	$ 3,201,957	$ 1,011,565	$ 4,213,522
2	Less: Allowances	1,597,426	1,713,039	144,509	1,857,548	1,919,493	592,210	2,511,703	2,096,555	628,335	2,724,890	2,278,861	666,663	2,945,524
3	Less: Charity Care	14,330	15,761	1,257	17,018	16,076	2,625	18,701	16,398	2,756	19,154	16,726	2,894	19,620
4	Less: Other Deductions	23,689	32,203	225	32,428	32,203	9,746	41,949	32,203	9,746	41,949	32,203	9,746	41,949
	Net Patient Service Revenue	**$ 798,352**	**$ 816,921**	**$ 78,102**	**$ 895,023**	**$ 828,941**	**$ 312,938**	**$ 1,141,879**	**$847,327**	**$ 322,558**	**$ 1,169,885**	**$874,167**	**$ 332,262**	**$1,206,429**
5	Medicare	306,149	304,839	32,217	337,056	323,804	127,442	451,246	328,423	130,173	458,596	331,579	132,837	464,416
6	Medicaid	100,599	83,178	12,973	96,151	86,713	51,391	138,104	87,119	51,470	138,589	87,611	51,492	139,103
7	CHAMPUS & TriCare	1,288	1,087	78	1,165	1,135	268	1,403	1,168	271	1,439	1,181	274	1,455
8	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Government	**$408,036**	**$389,104**	**$45,268**	**$434,372**	**$411,652**	**$179,101**	**$590,753**	**$416,710**	**$181,914**	**$598,624**	**$420,371**	**$184,603**	**$604,974**
9	Commercial Insurers	356,086	397,560	29,757	427,317	391,492	121,554	513,046	405,320	127,811	533,131	429,198	134,262	563,460
10	Uninsured	22,159	17,934	195	18,129	16,141	736	16,877	15,334	744	16,078	14,567	751	15,318
11	Self Pay	-	-		-	-	-	-	-	-	-	-	-	-
12	Workers Compensation	12,071	12,324	2,499	14,823	9,656	10,250	19,906	9,963	10,778	20,741	10,031	11,322	21,353
13	Other	-	-	383	383	-	1,297	1,297	-	1,311	1,311	-	1,324	1,324
	Total Non-Government	**$ 390,316**	**$ 427,818**	**$ 32,834**	**$ 460,652**	**$ 417,289**	**$ 133,837**	**$ 551,126**	**$430,617**	**$ 140,644**	**$ 571,261**	**$453,796**	**$ 147,659**	**$601,455**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 798,352**	**$ 816,922**	**$ 78,102**	**$ 895,024**	**$ 828,941**	**$ 312,938**	**$ 1,141,879**	**$847,327**	**$ 322,558**	**$ 1,169,885**	**$874,167**	**$ 332,262**	**$1,206,429**
14	Less: Provision for Bad Debts	25,600	27,828	2,522	**30,350**	24,220	10,490	**34,710**	$22,817	11,014	**33,831**	$21,200	11,565	**$32,765**
	Net Patient Service Revenue less provision for bad debts	**$ 772,752**	**$ 789,093**	**$ 75,580**	**$ 864,673**	**$ 804,721**	**$ 302,449**	**$ 1,107,170**	**$824,510**	**$ 311,544**	**$ 1,136,054**	**$852,967**	**$ 320,697**	**$1,173,664**
15	Other Operating Revenue	39,526	40,570	1,936	**42,506**	42,000	7,253	**49,253**	43,100	7,253	**50,353**	44,300	7,253	**51,553**
17	Net Assets Released from Restrictions	10,904	10,212	-	**10,212**	9,400	733	**10,133**	9,400	733	**10,133**	9,500	733	**10,233**
	TOTAL OPERATING REVENUE	**$823,182**	**$839,875**	**$77,516**	**$917,391**	**$856,121**	**$310,435**	**$1,166,556**	**$877,010**	**$319,530**	**$1,196,540**	**$906,767**	**$328,683**	**$1,235,450**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$ 378,047	$ 392,253	$ 33,702	$ 425,955	$ 396,501	$ 136,251	$ 532,752	$ 405,935	$ 139,657	$ 545,592	$ 420,297	$ 143,149	$ 563,446
2	Fringe Benefits	86,980	93,031	7,579	100,610	97,757	31,367	129,124	100,722	32,151	132,873	104,543	32,955	137,498
3	Physicians Fees	24,837	25,805	2,900	28,705	26,321	11,362	37,683	26,847	11,703	38,550	27,652	12,054	39,706
4	Supplies and Drugs	128,031	128,006	11,799	139,805	125,387	50,720	176,107	128,259	52,500	180,759	131,465	55,125	186,590
5	Depreciation and Amortization	39,696	39,743	2,919	42,662	42,891	12,064	54,955	45,164	12,426	57,590	47,422	12,799	60,221
6	Provision for Bad Debts-Other[b]	-	-	-	-	-	-	-	-	-	-	-	-	-
7	Interest Expense	11,152	10,950	58	11,008	10,427	219	10,646	10,140	208	10,348	9,861	198	10,059
8	Malpractice Insurance Cost	6,910	12,831	1,479	14,310	13,088	6,035	19,123	13,349	6,156	19,505	13,683	6,279	19,962
9	Lease Expense	9,883	11,084	-	11,084	11,305	-	11,305	11,532	-	11,532	11,820	-	11,820
10	Other Operating Expenses	130,060	123,920	14,180	138,100	119,222	55,944	175,166	118,759	56,275	175,034	121,814	57,401	179,215
	TOTAL OPERATING EXPENSES	**$ 815,596**	**$ 837,623**	**$ 74,616**	**$ 912,239**	**$ 842,899**	**$ 303,963**	**$ 1,146,862**	**$ 860,707**	**$ 311,078**	**$ 1,171,785**	**$888,557**	**$ 319,960**	**$1,208,517**
		$ 350,569	**$ 352,339**			**$ 348,641**			**$ 354,050**			**$ 363,717**		
	INCOME/(LOSS) FROM OPERATIONS	**$ 7,586**	**$ 2,252**	**$ 2,900**	**$ 5,152**	**$ 13,222**	**$ 6,472**	**$ 19,694**	**$ 16,303**	**$ 8,453**	**$ 24,756**	**$18,210**	**$ 8,723**	**$26,933**
	NON-OPERATING REVENUE	(21,308)	-	**652**	**652**	**-**	**2,963**	**2,963**	**-**	**3,052**	**3,052**	**$0**	**3,144**	**$3,144**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (13,722)**	**$ 2,252**	**$ 3,552**	**$ 5,804**	**$ 13,222**	**$ 9,435**	**$ 22,657**	**$ 16,303**	**$ 11,505**	**$ 27,808**	**$18,210**	**$ 11,867**	**$30,077**
	Principal Payments	**$8,785**	**$8,172**	$0	**$8,172**	**$7,673**	$3,000	**$10,673**	**$6,271**	$3,000	**$9,271**	**$6,539**	$3,000	**$9,539**

Applicant: Trinity Health - New England, Inc. **NON-PROFIT**

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.9%	0.3%	3.7%	0.6%	1.5%	2.1%	1.7%	1.9%	2.6%	2.1%	2.0%	2.6%	2.2%
2	Hospital Non Operating Margin	-2.7%	0.0%	0.8%	0.1%	0.0%	0.9%	0.3%	0.0%	0.9%	0.3%	0.0%	0.9%	0.3%
3	Hospital Total Margin	-1.7%	0.3%	4.5%	0.6%	1.5%	3.0%	1.9%	1.9%	3.6%	2.3%	2.0%	3.6%	2.4%
D.	**FTEs**	4,774.7	4,838.0	438.5	5,276.5	4,791.9	1,797.1	6,589.0	4,815.9	1,797.1	6,613.0	4,841.9	1,797.1	6,639.0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	32,337	33,071	2,925	**35,996**	32,316	11,816	**44,132**	32,408	11,757	**44,165**	32,250	11,698	**43,948**
2	Outpatient Visits	1,040,563	1,056,955	64,093	**1,121,048**	1,075,133	251,543	**1,326,676**	1,093,645	256,574	**1,350,219**	1,112,497	261,706	**1,374,203**
	TOTAL VOLUME	**1,072,900**	**1,090,026**	**67,018**	**1,157,044**	**1,107,449**	**263,359**	**1,370,808**	**1,126,053**	**268,331**	**1,394,384**	**1,144,747**	**273,404**	**1,418,151**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Saint Francis Hospital and Medical Center (without affiliates and subsidiaries) **NON-PROFIT**

Applicant:

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$ 2,104,370	$ 2,183,919	$ -	$ 2,183,919	$ 2,336,793	$ -	$ 2,336,793	$ 2,500,369	$ -	$ 2,500,369	$ 2,675,395	$ -	$ 2,675,395
2	Less: Allowances	1,396,910	1,466,182	-	1,466,182	1,601,089	-	1,601,089	1,749,382	-	1,749,382	1,900,716	-	1,900,716
3	Less: Charity Care	13,559	13,796	-	13,796	14,072	-	14,072	14,353	-	14,353	14,640	-	14,640
4	Less: Other Deductions	23,689	32,203	-	32,203	32,203	-	32,203	32,203	-	32,203	32,203	-	32,203
	Net Patient Service Revenue	**$ 670,212**	**$ 671,738**	**$ -**	**$ 671,738**	**$ 689,429**	**$ -**	**$ 689,429**	**$ 704,431**	**$ -**	**$ 704,431**	**$727,836**	**$ -**	**$727,836**
5	Medicare	264,123	255,713	-	255,713	274,505	-	274,505	278,138	-	278,138	280,289	-	280,289
6	Medicaid	83,037	64,842	-	64,842	67,839	-	67,839	67,868	-	67,868	67,976	-	67,976
7	CHAMPUS & TriCare	1,147	909	-	909	945	-	945	974	-	974	982	-	982
8	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Government	**$348,307**	**$321,464**	**$ -**	**$321,464**	**$343,289**	**$ -**	**$343,289**	**$346,980**	**$ -**	**$346,980**	**$349,247**	**$ -**	**$349,247**
9	Commercial Insurers	295,682	323,052	-	323,052	323,108	-	323,108	334,808	-	334,808	356,539	-	356,539
10	Uninsured	15,510	15,280	-	15,280	13,752	-	13,752	13,064	-	13,064	12,411	-	12,411
11	Self Pay	-	-	-	-	-	-	-	-	-	-	-	-	-
12	Workers Compensation	10,713	11,942	-	11,942	9,280	-	9,280	9,579	-	9,579	9,639	-	9,639
13	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Non-Government	**$ 321,905**	**$ 350,274**	**$ -**	**$ 350,274**	**$ 346,140**	**$ -**	**$ 346,140**	**$ 357,451**	**$ -**	**$ 357,451**	**$378,589**	**$ -**	**$378,589**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 670,212**	**$ 671,738**	**$ -**	**$ 671,738**	**$ 689,429**	**$ -**	**$ 689,429**	**$ 704,431**	**$ -**	**$ 704,431**	**$727,836**	**$ -**	**$727,836**
14	Less: Provision for Bad Debts	20,981	23,320	-	**23,320**	20,400	-	**20,400**	19,000	-	**19,000**	17,300	-	**$17,300**
	Net Patient Service Revenue less provision for bad debts	**$ 649,231**	**$ 648,418**	**$ -**	**$ 648,418**	**$ 669,029**	**$ -**	**$ 669,029**	**$ 685,431**	**$ -**	**$ 685,431**	**$710,536**	**$ -**	**$710,536**
15	Other Operating Revenue	31,260	29,397	-	**29,397**	29,985	-	**29,985**	30,585	-	**30,585**	31,197	-	**31,197**
17	Net Assets Released from Restrictions	4,156	3,647	-	**3,647**	3,720	-	**3,720**	3,794	-	**3,794**	3,870	-	**3,870**
	TOTAL OPERATING REVENUE	**$684,647**	**$681,462**	**$0**	**$681,462**	**$702,734**	**$0**	**$702,734**	**$719,810**	**$0**	**$719,810**	**$745,603**	**$0**	**$745,603**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$ 257,621	$ 256,489	$ -	$ 256,489	$ 268,882	$ -	$ 268,882	$ 275,833	$ -	$ 275,833	$ 285,292	$ -	$ 285,292
2	Fringe Benefits	68,083	71,139	-	71,139	78,965	-	78,965	81,344	-	81,344	83,784	-	83,784
3	Physicians Fees	44,673	47,053	-	47,053	47,994	-	47,994	48,954	-	48,954	50,423	-	50,423
4	Supplies and Drugs	106,637	105,873	-	105,873	105,032	-	105,032	107,445	-	107,445	110,132	-	110,132
5	Depreciation and Amortization	37,714	37,700	-	37,700	40,581	-	40,581	42,734	-	42,734	44,871	-	44,871
6	Provision for Bad Debts-Other[b]	-	-	-	-	-	-	-	-	-	-	-	-	-
7	Interest Expense	11,620	10,950	-	10,950	10,427	-	10,427	10,140	-	10,140	9,861	-	9,861
8	Malpractice Insurance Cost	10,303	10,333	-	10,333	10,539	-	10,539	10,750	-	10,750	11,019	-	11,019
9	Lease Expense	7,134	7,047	-	7,047	7,188	-	7,188	7,331	-	7,331	7,515	-	7,515
10	Other Operating Expenses	138,217	135,863	-	135,863	126,592	-	126,592	126,980	-	126,980	130,226	-	130,226
	TOTAL OPERATING EXPENSES	**$ 682,002**	**$ 682,447**	**$ -**	**$ 682,447**	**$ 696,200**	**$ -**	**$ 696,200**	**$ 711,511**	**$ -**	**$ 711,511**	**$733,123**	**$ -**	**$733,123**
	INCOME/(LOSS) FROM OPERATIONS	**$ 2,645**	**$ (985)**	**$ -**	**$ (985)**	**$ 6,534**	**$ -**	**$ 6,534**	**$ 8,299**	**$ -**	**$ 8,299**	**$12,480**	**$ -**	**$12,480**
	NON-OPERATING REVENUE	(20,060)	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**$0**	**-**	**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (17,415)**	**$ (985)**	**$ -**	**$ (985)**	**$ 6,534**	**$ -**	**$ 6,534**	**$ 8,299**	**$ -**	**$ 8,299**	**$12,480**	**$ -**	**$12,480**
	Principal Payments	**$8,785**	**$8,172**	$0	**$8,172**	**$7,673**	$0	**$7,673**	**$6,271**	$0	**$6,271**	**$6,539**	$0	**$6,539**

Applicant: Saint Francis Hospital and Medical Center (without affiliates and subsidiaries) NON-PROFIT

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.4%	-0.1%	0.0%	-0.1%	0.9%	0.0%	0.9%	1.2%	0.0%	1.2%	1.7%	0.0%	1.7%
2	Hospital Non Operating Margin	-3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-2.6%	-0.1%	0.0%	-0.1%	0.9%	0.0%	0.9%	1.2%	0.0%	1.2%	1.7%	0.0%	1.7%
D.	**FTEs**	3,684.8	3,616.7	0.0	3,616.7	3,699.0	0.0	3,699.0	3,702.0	0.0	3,702.0	3,718.0	0.0	3,718.0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	31,632	32,188	-	**32,188**	31,557	-	**31,557**	31,649	-	**31,649**	31,491	-	**31,491**
2	Outpatient Visits	294,633	296,106	0	**296,106**	299,067	0	**299,067**	302,058		**302,058**	305,078	0	**305,078**
	TOTAL VOLUME	**326,265**	**328,294**	**0**	**328,294**	**330,624**	**0**	**330,624**	**333,707**	**0**	**333,707**	**336,569**	**0**	**336,569**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Exhibit 17 Financial Statistics

Trinity Health - New England

Monthly Financial Measurement/Indicators	September 15 YTD	September 14 YTD	September 15 MTD	September 14 MTD	Comments
A. Operating Performance:					
Operating Margin	0.9%	1.3%	(5.5%)	7.8%	operating income/operating revenues
Non-Operating Margin	NA	NA	NA	NA	
Total Margin	7.1%	7.4%	1.0%	13.8%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.1%	1.2%	0.4%	0.8%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio	2.0	2.1	2.0	2.1	current assets/current liabilites
Days Cash on Hand	NA	NA	NA	NA	See SFH for Reported DCOH measurement
Days in Net Accounts Receivables	36.6	40.9	36.6	40.9	net ar/net patient ser rev/days in yr
Average Payment Period	57.9	57.4	57.9	57.4	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity	134.9%	113.9%	134.9%	113.9%	total debt/total equity(net assets)
Long-term Debt to Capitalization	57.4%	53.3%	57.4%	53.3%	LTD/LTD+net assets
Unrestricted Cash to Debt	71.7%	67.2%	71.7%	67.2%	cash =DCOH calc
Times Interest Earned Ratio	1.7	1.9	(2.9)	7.0	EBIT/Interest expense
Debt Service Coverage Ratio	2.9x*	2.7x**	2.9x*	2.7x**	quarter end (use Jun)/ same as SFHMC reported for DSC measurement
Equity Financing Ratio	20.8%	25.2%	20.8%	25.2%	Net assets/total assets
D. Additional Statistics					
Income(Loss) from Operations	7,585,990	10,367,192	(3,651,235)	5,514,737	Net income(loss) from operations
Revenue Over/(Under) Expense	(13,722,368)	12,724,139	(15,314,845)	4,270,976	Net gain(loss)
EBITDA	58,433,786	59,874,237	672,529	9,757,223	based on net income(loss) from operations
Patient Cash Collected	NA	NA	NA	NA	
Cash and Cash Equivalents	102,071,359	93,155,487	102,071,359	93,155,487	from cons bs
Net Working Capital	120,191,181	125,356,264	120,191,181	125,356,264	current assets-current liabilities
Unrestricted Assets	101,674,917	137,311,648	101,674,917	137,311,648	from cons bs

*Measurement data is Sept 30, 2015

**Measurement data is Sept 30,2014

Exhibit 17 Financial Statistics

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Saint Francis Hospital and Medical Center (unaudited)

	September 15 YTD	September 14 YTD	September 15 MTD	September 14 MTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin	0.4%	2.1%	-10.3%	3.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	NA	NA	
Total Margin	7.6%	9.1%	-2.7%	10.1%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.0%	1.1%	0.01%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio	1.9	2.0	1.9	2.0	current assets/current liabilites
Days Cash on Hand	89*	89**	89*	89**	quarter end
Days in Net Accounts Receivables	36.7	39.9	36.7	39.9	net ar/net patient ser rev/days in yr
Average Payment Period	54.4	56.3	54.4	56.3	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity	188.1%	138.4%	188.1%	138.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	65.3%	58.1%	65.3%	58.1%	LTD/LTD+net assets
Unrestricted Cash to Debt	64.0%	60.8%	64.0%	60.8%	as calculated monthly
Times Interest Earned Ratio	1.3	2.2	-4.9	3.1	EBIT/Interest expense
Debt Service Coverage Ratio	2.9x*	2.7x**	3.8x*	2.7x**	quarter end (use jun)
Equity Financing Ratio	17.3%	23.3%	17.3%	23.3%	Net assets/total assets
D. Additional Statistics					
Income(Loss) from Operations	2,884,906	14,421,395	(5,557,203)	1,893,738	Net income(loss) from operations
Revenue Over/(Under) Expense	(17,175,330)	15,620,119	(16,763,738)	1,267,802	Net gain(loss)
EBITDA	51,750,212	61,840,788	(1,433,534)	5,860,101	based on net income(loss) from operations
Patient Cash Collected	NA	NA	NA	NA	
Cash and Cash Equivalents	76,693,459	70,506,821	76,693,459	70,506,821	from cons bs
Net Working Capital	83,760,221	100,331,512	83,760,221	100,331,512	current assets-current liabilities
Unrestricted Assets	52,170,274	100,019,901	52,170,274	100,019,901	from cons bs or rollforward

*Measurement data is Sept 30, 2015

**Measurement data is Sept 30,2014

Saint Francis Hospital and Medical Center

	September 15 YTD	September 14 YTD	
D. Additional Statistics			
Income(Loss) from Operations	2,884,906	14,421,395	Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees.
Revenue Over/(Under) Expense	(17,175,330)	15,620,119	Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($16.8M).
EBITDA	51,750,212	61,840,788	Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees.
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	76,693,459	70,506,821	Decrease in a/r patient ($5.7), Increase in a/p $3.7M. Intercompany paydown of receivable $10M.
Net Working Capital	83,760,221	100,331,512	Decrease in a/r patient ($5.7), Increase in a/p $3.7M.
Unrestricted Assets	52,170,274	100,019,901	Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($17.5M). Pension funding and post retirement liability of ($18M), transfer to affiliate ($14M).

EXHIBIT 18

Saint Mary's
HOSPITAL

Office of the President
Chad W. Wable, FACHE

December 19, 2013

Mr. George C. Jepsen
Attorney General
State of Connecticut
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Re: Response to Request for Information – Disclosure of Facility Fees

Dear Mr. Jepsen:

Enclosed are answers to the questions you sent on November 19, 2013 regarding disclosure of facility fees for off-campus hospital-based providers.

If you have additional questions, please feel free to reach out to me or to Silvia Hutcheson, Director of Strategic Planning and Business Development at Saint Mary's Hospital. Silvia can be reached at (203) 709-3312.

I look forward to working with you further on providing meaningful transparency and cost information to consumers during this time of healthcare transformation.

Sincerely,

Chad W. Wable, FACHE
President and Chief Executive Officer

Enclosures

cc: Robert J. Anthony, Esq., Brown Rudnick, LLC
Silvia Hutcheson, Saint Mary's Hospital
James Iacobellis, Connecticut Hospital Association

Saint Mary's
HOSPITAL

Request for Information: Disclosure of Facility Fees

Submitted by Saint Mary's Hospital
December 19, 2013

1. *Please provide the name, address, specialty type and contact information for each of your off-campus hospital-based providers that currently charges a facility fee.*

Ambulatory Surgery

Name: Saint Mary's Naugatuck Valley Surgical Center
Address: 160 Robbins Street, Waterbury, CT 06708
Specialty: Ambulatory Surgery
Contact Information: The phone number is (203) 755-6663.

Cardiac Testing

Name: Saint Mary's Cardiovascular Diagnostic Center
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Imaging Services (Nuclear Medicine and Carotid Ultrasound) and Cardiac Testing (Echocardiography, Holter Monitoring, and Stress Testing)
Contact Information: The phone number is (203) 709-4506.

Imaging Services

Name: Saint Mary's Medical Imaging Center
Address: 475 Chase Parkway, Waterbury, CT 06708
Specialty: Imaging Services (Outpatient MRI)
Contact Information: The telephone number is (203) 709-5550.

Urgent Care (Two Locations)

First Location
Name: Saint Mary's Naugatuck Urgent Care Center
Address: 799 New Haven Road, Crosspointe Plaza, Naugatuck, CT 06770
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 723-5636.

Second Location
Name: Saint Mary's Wolcott Urgent Care Center
Address: 503 Wolcott Road, Wolcott, CT 06716
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 879-7900.

2. *The name and address of each of your off-campus hospital-based provider(s) that currently <u>does not</u> charge a facility fee. For such provider identified, identify the specialty type and state the reason why the provider does not charge a facility fee.*

Franklin Medical Group, PC, which is an affiliate of Saint Mary's Health System, employs Primary Care and Specialty Care healthcare providers. These healthcare providers do not charge facility fees for services. Services are billed through CPT codes at the physician rate. There are fourteen locations in the community. The locations are listed below:

Location One
Name: Franklin Medical Group
Address: 133 Scovill Street, Waterbury, CT 06706
Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary

Location Two
Name: Franklin Medical Group
Address: 95 Scovill Street, Waterbury, CT 06706
Specialties: Internal Medicine and Pediatrics

Location Three
Name: Franklin Medical Group Behavioral Healthcare Outpatient Services
Address: 100 Jefferson Square, Waterbury, CT 06706
Specialties: Outpatient Behavioral Health Services

Location Four
Name: Franklin Medical Group
Address: 1981 East Main Street, Waterbury, CT 06705
Specialties: Internal Medicine

Location Five
Name: Franklin Medical Group
Address: 202 Water Street, Naugatuck, CT 06770
Specialties: Internal Medicine

Location Six
Name: Franklin Medical Group Primary Care Partners
Address: 166 Waterbury Road, Prospect, CT 06712
Specialty: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery, and Breast Surgery

Location Seven
Name: Franklin Medical Group Wolcott Internal Medicine
Address: 503 Wolcott Road, First Floor, Wolcott, CT 06716
Specialty: Internal Medicine

Location Eight
Name: Franklin Medical Group Breast and Oncology Center
Address: 33 Bullet Hill Road, Suite 214, Southbury, CT 06488
Specialty: General Surgery and Breast Surgery

Location Nine
Name: Franklin Medical Group
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Cardiology, Pulmonary (Sleep Medicine)

Location Ten
Name: Franklin Medical Group
Address: 140 Grandview Avenue, Suite 4, Waterbury, CT 06708
Specialty: Gastroenterology

Location Eleven
Name: Franklin Medical Group
Address: 590 Middlebury Road, Suite A, Middlebury, CT 06762
Specialty: General Surgery

Location Twelve
Name: Franklin Medical Group
Address: 1389 West Main Street, Waterbury, CT 06708
Specialty: General Surgery

Location Thirteen
Name: Franklin Medical Group
Address: 70 Heminway Park Road, Watertown, CT 06795
Specialty: Internal Medicine

Location Fourteen
Name: Franklin Medical Group
Address: 56 Franklin Street, Second Floor, Waterbury, CT 06706
Specialty: Cardiology

Saint Mary's Naugatuck Valley Surgical Center

3. *For **Saint Mary's Naugatuck Valley Surgical Center**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

        Patients receive a packet of information in the mail when surgery is scheduled at least two days in advance of the surgery. The packet includes a Patient Letter, a Patient Handbook as well as forms and questionnaires to complete. The Patient Letter is included as Attachment One, and the Patient Handbook is included as Attachment Two. The Patient Letter states that the Naugatuck Valley Surgical Center is an off-site department and is 100% owned by Saint Mary's Hospital. The Patient Handbook states that as an off-site department of the hospital, the surgery center services are charged at the same rate as the hospital.

    b. *That the provider charges separate professional and facility fees:*

        Patients are informed through the Patient Handbook that separate professional fees and facility fees will be charged.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

        An insurance associate informs patients of their co-payment responsibilities in advance of the surgery. The co-payment is collected prior to surgery.

        Patients who receive services that are not covered by insurance are given a Patient Charge Estimate sheet, which is included as Attachment Three.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

        Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

The Patient Handbook (Attachment Two) directs patients to contact their insurance carrier with questions.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

The Patient Letter (Attachment One) and the Patient Handbook (Attachment Two) are mailed to patients when their surgery is scheduled at least two days in advance.

Patients who are booked just prior to their surgical date receive the Patient Handbook on the day of surgery. These include patients who are booked on the day of their surgery or the day before their surgery.

All patients sign the Authorization for Treatment (Attachment Four) on the day of surgery.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

Patients sign the Authorization for Treatment (Attachment Four), which is hand-delivered, when they arrive for surgery.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

   a. *Signage*

      Signage throughout the surgery center includes the Saint Mary's logo and disclosure of 100% ownership by the hospital. A picture of the signage and ownership disclosure is included as Attachment Five.

   b. *Marketing materials*

      The marketing materials, such as the Patient Handbook (Attachment Two), include the Saint Mary's logo.

   c. *Websites;*

      The website includes the Saint Mary's logo and also states that the ambulatory surgery center is a department of Saint Mary's Hospital. The home page of the Naugatuck Valley Surgical Center website is included as Attachment Eight.

   d. *Stationary; and*

      Stationary, such as the Patient Letter (Attachment One), Discharge Instruction Sheets (Attachment Six), and Prescription Pads (Attachment Seven), include the Saint Mary's Hospital logo.

   e. *Other means of disclosure*

      Business cards of Naugatuck Valley Surgical Center employees include the Saint Mary's logo.

Saint Mary's Cardiovascular Diagnostic Center

3. *For **Saint Mary's Cardiovascular Diagnostic Center**, state whether you require that the provider disclose to patients, in writing:*

a. That the provider is owned, affiliated or part of a joint venture with your hospital:

Patients sign a Cardiovascular Diagnostic Center Billing Form, which is included as Attachment Nine. Patients sign this form prior to receiving services.

b. That the provider charges separate professional and facility fees:

The Cardiovascular Diagnostic Center Billing Form states that the provider charges separate professional and facility fees.

c. The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:

Patients are given estimates only upon request by the patient or family member.

d. An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

e. An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. *That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Cardiovascular Diagnostic Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. *Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

Written notice is not provided when the appointment is scheduled.

b. *Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

Patients sign the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Authorization for Treatment (Attachment Four) on the day of service. Both documents are hand-delivered.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. *Signage*

Signage throughout the Cardiovascular Diagnostic Center includes the Saint Mary's logo. A picture of the Cardiovascular Diagnostic Center signage is included in the brochure, which is Attachment Ten.

b. *Marketing materials*

Marketing materials, such as the Cardiovascular Diagnostic Center Brochure (Attachment Ten), include the Saint Mary's logo.

c. Websites;

The Cardiovascular Diagnostic Center does not have a website at this time.

d. Stationary; and

Stationary, such as the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Appointment Cards (Attachment Eleven), include the Saint Mary's Hospital logo.

e. Other means of disclosure

Not applicable.

Saint Mary's Medical Imaging Center

3. *For **Saint Mary's Medical Imaging Center**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

Patients sign the Authorization for Treatment (Attachment Four). The Saint Mary's Medical Imaging Center does not provide additional written materials about ownership by the hospital.

    b. *That the provider charges separate professional and facility fees:*

The Authorization for Treatment (Attachment Four) states that the provider charges separate professional and facility fees.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

Patients are given estimates only upon request by the patient or family member.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

    f. *A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Saint Mary's Medical Imaging Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

Written notice is not provided when the appointment is scheduled.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

The Authorization for Treatment (Attachment Four) is hand-delivered. Patients sign the Authorization for Treatment on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. Signage

Signage throughout the Medical Imaging Center includes the Saint Mary's logo.

b. Marketing materials

Marketing materials include the Saint Mary's logo.

c. Websites;

The hospital website lists the Saint Mary's Medical Imaging Center as a hospital service. Attachment Twelve includes the Saint Mary's Hospital webpage on Patient Services.

d. Stationary; and

Not applicable.

e. Other means of disclosure

Not applicable.

Saint Mary's Urgent Care Centers

3. *For **Saint Mary's Urgent Care Centers**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

Patients sign two forms when they arrive for service at the Urgent Care Centers. The first form is the Acknowledgement of Disclosure, which is included as Attachment Thirteen. This Acknowledgement of Disclosure states specifically that the center is no longer a "Walk-In" Center (effective November 18, 2012). Patients also sign the Authorization for Treatment (Attachment Four).

    b. *That the provider charges separate professional and facility fees:*

Both forms state that the provider charges separate professional and facility fees.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

Patients are given estimates only upon request by the patient or family member.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Urgent Care Centers do not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

Appointments for Urgent Care services are not scheduled in advance.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

The forms are hand-delivered. Patients sign the Authorization for Treatment (Attachment Four) and the Acknowledgement of Disclosure (Attachment Thirteen) on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. Signage

Signage throughout the Urgent Care Centers includes the Saint Mary's logo. Attachment Fourteen includes pictures of the signage at the entrance of the Urgent Care Centers.

b. Marketing materials

Marketing materials, such as the yellow banner in the lobbies of the Urgent Care Centers, includes the Saint Mary's logo. A picture of these banners is included as Attachment Fifteen.

c. Websites;

The hospital website (Attachment Twelve) lists the Saint Mary's Urgent Care Centers as a hospital service.

d. Stationary; and

Stationary, such as the letter included as Attachment Sixteen, includes the Saint Mary's logo.

e. Other means of disclosure

A sign, which is included as Attachment Seventeen, is in the registration area of the Urgent Care Centers. This sign is another example of how patients are informed that they will receive separate bills for physician services and facility fees.

Saint Mary's
HOSPITAL

Attachments

Attachment One: Patient Letter

Attachment Two: Patient Handbook

Attachment Three: Patient Charge Estimate

Attachment Four: Authorization for Treatment

Attachment Five: Naugatuck Valley Surgical Center Signage and Ownership Disclosure

Attachment Six: Discharge Instructions

Attachment Seven: Prescription Blanks

Attachment Eight: Naugatuck Valley Surgical Center Website

Attachment Nine: Cardiovascular Diagnostic Center Billing Form

Attachment Ten: Saint Mary's Cardiovascular Diagnostic Center Brochure

Attachment Eleven: Saint Mary's Cardiovascular Diagnostic Center Appointment Card

Attachment Twelve: Saint Mary's Hospital Website on Patient Services

Attachment Thirteen: Acknowledgement of Disclosure

Attachment Fourteen: Urgent Care Center Signage

Attachment Fifteen: Urgent Care Center Banner

Attachment Sixteen: Urgent Care Center Letter

Attachment Seventeen: Urgent Care Center Sign in Registration Area

NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

Dear Patient, Parent or Guardian:

The Naugatuck Valley Surgical Center is dedicated to providing exceptional patient quality care. To assist in obtaining all of the important information we need to know about you, please **completely** fill out the enclosed **"Patient Data Form", "Health Questionnaire" and "Medication Reconciliation"** sheet.

Please return the completed forms in the enclosed envelope as soon as possible, or Fax to 203-756-9645.

***If your procedure is within 3 days of the receipt of these forms, please fax or bring the completed forms with you on the day of your procedure.

Preparing for your surgery can make the day of surgery less stressful. A nurse from the surgical center will call you prior to your surgery to review your medical history, notify you of the time of your surgery and give you instructions. Depending on your health history, you may be required to have pre-admission testing performed. You will also be required to have someone drive you home and stay with you for 24 hours after the procedure. **IF YOU WILL NOT BE HOME TO RECEIVE THIS CALL, PLEASE CONTACT THE SURGICAL CENTER BEFORE NOON THE DAY BEFORE YOUR PROCEDURE.** Also, if at any time prior to your surgery you become ill or have any new health problems, please contact your physician and the Surgical Center. Changes in your health may impact your physician's decision to perform your procedure.

INSURANCE CARDS: Please bring your insurance cards with you on the day of the surgery. We will also need to copy your driver's license or picture identification.

INSURANCE CO-PAYS: You will be responsible for any **"Hospital One Day Surgery"** co-pay required by your insurance company. This is due on the day of the surgery. We will submit all of your NVSC facility charges to your insurance carrier. If there is an outstanding balance, the billing department will send a statement with your balance due. They are also available to set up payment arrangements prior to your procedure. For your convenience, we accept cash, credit cards, debit cards and personal or bank checks. If you elect to place a credit card on file, charges will be applied for the balance due.

PRE-AUTHORIZATION: If your insurance company requires pre-authorization, please make sure that your physician takes care of this prior to your procedure.

PATIENT BILL OF RIGHTS & RESPONSIBILITIES A copy of the "Patient Bill of Rights and Responsibilities" are included with information on "Your Rights to Make Health Care Decisions".

OWNERSHIP: The Naugatuck Valley Surgical Center is an off site department and 100% owned by Saint Mary's Hospital.

If you have any questions about the information provided or requested, please contact us at (203) 755-6663

160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663 • FAX (203) 756-9645

Directions

From the North:
Take Route 8 South to Exit 33 (Interstate 84 West) and follow directions below.

From the South:
Take Route 8 north to Exit 33 (Interstate 84 West) and follow directions below.

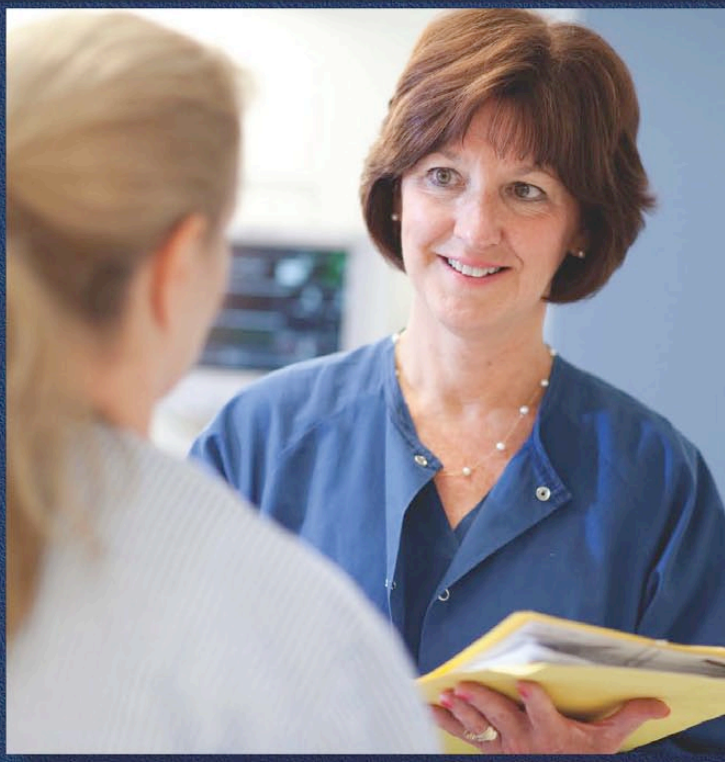
From the East:
Take Interstate 84 West to Exit 18. Bear left on the exit ramp for West Main Street. At the end of the exit ramp, turn right onto West Main Street. After the first light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

From the West:
Take Interstate 84 East to Exit 18 (Chase Parkway). At the end of the exit ramp, turn right onto Chase Parkway. Proceed to light, turn right and cross over the highway. At the next light, turn right onto West Main Street. After the second light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

160 Robbins Street
Waterbury, CT 06708
(203) 755-6663
nvsc.org
info@nvsc.org



Patient Handbook

What you need to know before surgery

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

Welcome

Betty Bozzuto
Vice President
Surgical Services

Welcome to the Naugatuck Valley Surgical Center. As a department of Saint Mary's Hospital, we are committed to providing exceptional care to every patient, every day.

Your surgeon has chosen our surgical center for our skill and our reputation of delivering high quality and individualized care to this community since 1986. Here, your surgeon works with highly qualified anesthesiologists, CRNAs, registered nurses and support staff in a facility equipped with state-of-the-art technology. Our surgical center staff is experienced in gynecology, ophthalmology, orthopedics, gastroenterology, podiatry, otorhinolaryngology (ENT), urology, oral/dental surgery, general surgery, plastic surgery and pain management.

You may be interested to know that over 70% of all surgery is now performed in an outpatient surgical setting similar to this one.

You can expect personalized care – because you are important to us.

During your stay, you can expect:

- A facility designed exclusively for and specializing in ambulatory surgery
- State-of-the-art operating rooms and post-operative patient care areas
- Individualized, high-quality care given in a warm, friendly setting
- Staff that is fully CPR, ACLS and PALS certified
- Thorough medical staff credentialing and Medical Advisory Board physician peer review
- Licensure by the State and Medicare Certification
- Cost-effective services with the same charge structure as Saint Mary's Hospital

Insurance & Billing

We participate with most local and national insurers, HMOs, PPOs, IPAs and Workers' Compensation carriers. We also participate with Medicare and most Medicaid programs.

For the services rendered at the time of your visit, your insurance company will be billed with the information that you provide for us. As an off-site department of Saint Mary's Hospital, our charges are the same as services at the hospital.

If you have any questions as to whether the Center participates with your insurance carrier, please contact our billing department or your insurance carrier. You are responsible for any deductibles, co-insurance or one day surgery co-pays. Co-pays are due at the time of your visit.

Dental surgery is paid with your hospital insurance, not your dental insurance. Check your coverage with your insurance carrier or employer.

You will receive a bill from Saint Mary's Hospital/ Naugatuck Valley Surgical Center for any balance that is billable to you after your insurance is paid. You will also receive a separate bill from your surgeon, anesthesiologist, pathology and/or radiology departments, depending on which services were utilized when you were a patient at our center.

Patients having non-covered or cosmetic procedures, or uninsured patients, are asked to settle their account before surgery is performed. Our Billing Associate will contact you with an estimate of charges for the procedure that your surgeon has scheduled for you. All charges are estimated and may differ from the estimate if additional or different procedures are performed. The patient is responsible for any additional charges that result. Any unpaid balance will be billed to you, and payment is requested within 30 days of receipt of statement.

Workers' Compensation

Workers' Compensation claims need additional information. Please make sure that you provide the following information on the "Patient Data" form: Workers' Compensation insurance carrier name and contact person, employer name and address, date and time of injury, and claim number.

Your Child & Surgery

As you might expect, surgery is often frightening to your child, mostly because the surroundings and the experience are unfamiliar. The Surgical Center staff will work with parents to reassure your child and make him/her feel at ease. All questions are important to us, and we encourage you to let us know of any concerns. We care.

Here is how we can help:

- Call us as soon as surgery is scheduled ***to arrange a personal tour*** for you and your child, if you so desire.
- ***A Surgical Center nurse will call before the day of surgery*** to confirm specific instructions about your child's operation. If you will not be available by phone, please call us the day before surgery, between 8:00 a.m. and 2:00 p.m.
- ***We will not leave your child alone***, not even for a minute. From admitting to recovery, our qualified staff will attend to your child's needs.

This is how you can help:

- ***Tell your child what to expect.*** Encourage him or her to ask questions. We are happy to discuss any questions your child may have at the time of your tour.
- ***Stay with your child.*** We recognize that a parent's presence is very comforting to a child. You may stay with your child until he/she is taken into the operating room. You will be reunited almost immediately following surgery.
- ***Bring your child's favorite blanket, toy or book.***
- ***Accompany your child under 18 years of age.*** A parent or guardian must remain at the Surgical Center while your child is in our facility. Parents and guardians must sign all consent forms for children under 18.

Before Surgery

Before surgery, ***call your surgeon*** if you have questions or if there is any change in your physical condition. You should call even if you just have a scratchy throat.

Ask about medication. If you take aspirin, medication containing aspirin, diet pills, blood thinners, or herbal supplements on a regular basis, please ask your doctor if and when you should stop taking them prior to your surgery. We may also give you instructions about medications.

You can expect a call before the day of surgery. A Surgical Center nurse will call you to confirm the time of your surgery, review your medical history and give you pre-operative instructions. These instructions are for your benefit, safety and comfort. If you are not available by phone, please call us the day before your surgery, between 8:00 a.m. and 4:00 p.m.

Each patient must have a history and physical form completed within 30 days of surgery. Ask your surgeon if he/she will complete the form, or see your medical doctor. Your surgeon will determine if any lab work is required prior to surgery.

Do not eat or drink anything — not even gum, hard candy or a glass of water — after midnight the night before your procedure, unless otherwise advised by the Surgical Center. Also, children may receive different instructions.

Arrange for a ride home. A responsible person must accompany you home. *You will not be permitted to drive yourself home.*

Please follow the rules for your safety and comfort. If you do not follow these rules, and the rules listed for the day of surgery, we may have to cancel your surgery for safety reasons.

Day of Surgery

Remember to follow these rules; they are designed for your safety, comfort, and convenience.

Arrive one hour and 15 minutes before your scheduled operation, unless directed otherwise. When you arrive, you will meet your anesthesiologist to discuss the best anesthetic for your surgery. You will also meet your nurses and other members of our staff who will be glad to assist you during your stay.

Do not eat or drink, including water, in the morning, unless otherwise advised by the Surgical Center.

Wear loose-fitting casual clothing that you can store in a locked drawer. We will provide a patient gown, bathrobe, and slippers for your surgery.

Please leave contact lenses at home. If you must bring them, bring a storage case and solution.

All body piercings should be removed.

Please leave all jewelry and valuables at home.

Do not wear makeup or fingernail polish.

Toenail polish should be removed if you are having any foot, knee or other leg surgery.

Bring your completed Patient Data Form, Health Questionaire, Medication Reconciliation and insurance forms if you have not already mailed them to us.

Bring your insurance ID card(s) and a photo ID.

Following Surgery

After your surgery, you will awaken in the comfortable atmosphere of the Post Anesthesia Care Unit (Recovery Room), where our professional staff will continue to monitor your recovery. Your nurse will encourage you to drink liquids and provide you with a large dose of personal attention.

When your anesthesiologist determines that you're ready to go home, your nurse will review your home care instructions with you and your family.

You may not drive yourself home. Someone must drive you home, as you may feel slightly sleepy or dizzy after anesthesia and medications.

The next 24 hours are important to your recovery. Even though surgery is behind you, you still need to allow time to recover at home.

Here is what you must do at home:

- ***Have a responsible adult with you and someone to stay home with you for the first 24 hours.***
- ***Do not drive or operate heavy equipment.***
- ***Follow the special instructions that your surgeon or our staff provided.***
- ***Do not take medications without your surgeon's approval.***
- ***Call your surgeon if you have unusual symptoms or changes in your condition that you were not expecting.***
- ***Do not drink any alcoholic beverages.***
- ***Expect to hear from us.*** Your Post Anesthesia Care Unit nurse will call the day after surgery to check your progress and answer any questions.
- ***Pamper yourself*** and avoid strenuous activity. Do not be fooled; you may feel fine immediately following surgery, but this is not the day to overdo it!
- ***Do not sign any legal documents.***

You may also receive a patient questionnaire following surgery. Please fill this form out and return it to us — your response and input means a lot to us.

Saint Mary's HOSPITAL

Patient Charge Estimate

for: pt

PATIENT NAME: _____
PATIENT PHONE: _____

PLANNED DOS:_____

PHYSICIAN NAME: _____
PHYSCIAN PHONE: _____

INSURANCE CO: _____
INSURANCE PHONE: _____

BENEFIT INFO: _____
_____
_____
_____
_____

PROPOSED PROCEDURE:
CPT CODE:_____ **FEE:**_____
CPT CODE:_____ **FEE:**_____
CPT CODE:_____ **FEE:**_____
ANESTHESIA FEE: _____ **FEE:**_____

NOTES: This estimate is based on the attached booking. This quote is subject to change if the physician changes the procedure.

_____
_____
_____

_____
pt signature **date**

Disclaimer

This is an estimate of charges for hospital services only. It is a good faith estimate based on the hospital's current price list, an average of previous procedures performed at Saint Mary's Hospital, and the treatment your physician is ordering for you. It is not legally binding. Your final bill may be more or less than this estimate. If you have overpaid us, we will promptly refund you. If you have not paid us enough, we expect additional payment from you.

Denegación

El siguiente es un estimado solo por servicios proveidos por el hospital. Es un estimado en buena fe basado en la lista de precios del hospital, un promedio del costo de procedimientos previos del hospital, y de el tratamiento ordenado por su medico. Su cuenta final puede ser mas o menos que la dicha en este estimado. En caso de un sobre pago al hospital, le reembolsaremos el sobrante. En caso de un corto pago, esperamos su saldo inmediato.

AUTHORIZATION FOR TREATMENT

I hereby give my consent to the hospitalization and treatment at Saint Mary's Hospital, which adheres to the Catholic Ethical and Religious Directives, encompassing routine Diagnostic testing and/or procedures which may include HIV-related tests, Medical and/or Surgical treatment and whatever Anesthesia deemed necessary by my (His, Her) Physician, His/Her Assistant or Designates. Upon presentation for outpatient services I acknowledge that I am under the care of the referring physician.

AUTHORIZATION TO RELEASE INFORMATION FOR SUBSEQUENT CARE

The undersigned hereby authorizes Saint Mary's Hospital to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary for referral to any medical practitioner and/or medical facility responsible for my subsequent care.

DISCLOSURE OF INFORMATION FOR PAYMENT

The undersigned hereby authorizes Saint Mary's Hospital and/or hospital based physicians to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF INSURANCE BENEFITS

I agree to pay all charges for services rendered to me between admission and discharge and/or all charges for ambulatory care or outpatient services. I hereby assign payment directly to Saint Mary's Hospital, 56 Franklin Street, Waterbury CT 06706 and/or hospital based physicians of the health insurance benefits otherwise payable to me but not to exceed the regular charges for this period of hospitalization and/or outpatient treatment. I understand that I will be responsible for charges not covered by my health insurance plan, which may include but is not limited to all co- payments, deductibles and non-covered services such as cosmetic surgery. I further agree that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed to Saint Mary's Hospital and/or hospital based physicians by myself or my family. If I am uninsured or otherwise unable to pay my medical bill, I understand that I can request to speak with a financial counselor to determine my eligibility for available financial assistance. **Please note: If you receive care from physician independent contractors and/or hospital based physicians such as anesthesiologists, radiologists, pathologists, or other physicians, you will receive a separate bill directly from them in addition to a hospital facility bill.**

SERVICES PROVIDED BY INDEPENDENT CONTRACTORS

I acknowledge and understand that the Anesthesia, Emergency, Radiology and Pathology services that I may receive at Saint Mary's Hospital will be provided by physicians who are self-employed, independent contractors. Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians, and they are not agents, servants, or employees of Saint Mary's Hospital. I also acknowledge that private attending physicians, and the consultants to whom they may refer my care and treatment, are also not agents, servants or employees of Saint Mary's Hospital, and Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians.

PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE) _____ DATE AND TIME _____ RELATIONSHIP _____

PATIENT UNABLE TO SIGN (INDICATE REASON) _____

WITNESSED BY _____ DATE AND TIME _____

NOTE: Parental consent required for unemancipated minors.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Saint Mary's Hospital Notice of Privacy Practices. The Notice describes how my health may be used or disclosed. I understand that I should read it carefully.

DATE _____ PRINT NAME _____ SIGNATURE _____

As the representative of the above patient, I acknowledge receipt of the Notice on his or her behalf.

DATE _____ PRINT NAME _____ SIGNATURE _____

FOR HOSPITAL USE ONLY* ☐Patient and family unable to sign ☐Patient refused to sign ☐Emergent Care Required

(Document comments) _____

_____ Signature / Date: _____

Saint Mary's HOSPITAL

56 Franklin Street, Waterbury, CT 06706

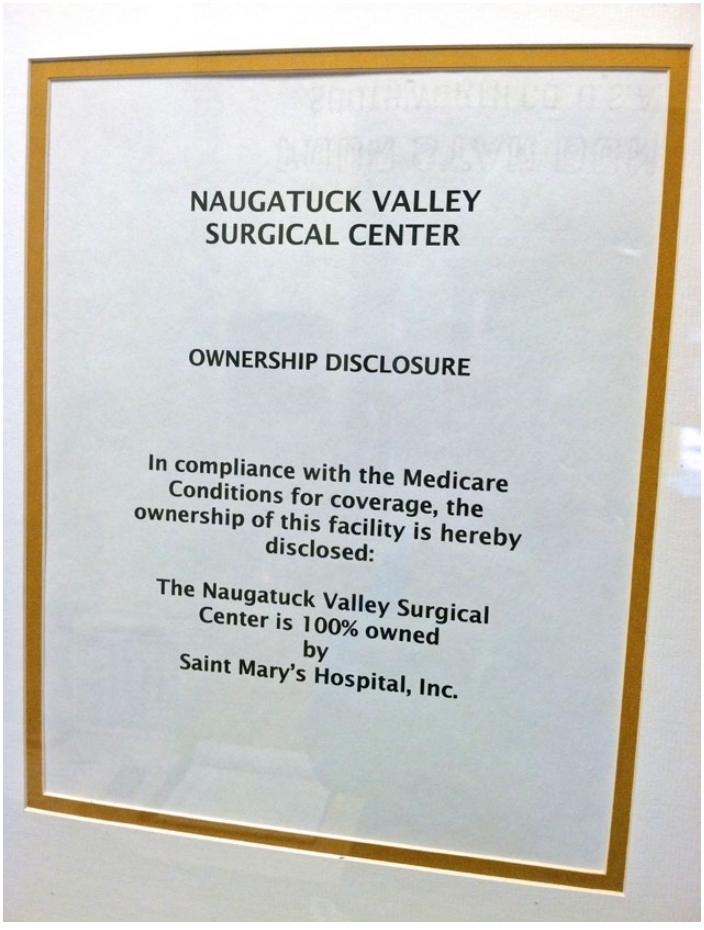
AUTHORIZATION FOR TREATMENT

Place Patient Label Above This Line

5313L

5313L R 11/14/12

NAUGATUCK VALLEY
SURGICAL CENTER
Saint Mary's Hospital


NAUGATUCK VALLEY
SURGICAL CENTER
OWNERSHIP DISCLOSURE
In compliance with the Medicare Conditions for coverage, the ownership of this facility is hereby disclosed:
The Naugatuck Valley Surgical Center is 100% owned by
Saint Mary's Hospital, Inc.

NAUGATUCK VALLEY SURGICAL CENTER
Saint Mary's Hospital
ENTRANCE
HOURS OF OPERATION
Mon.-Fri. 6:30 a.m. to 5:00 p.m.
Closed Saturday and Sunday
In the event of an AFTER HOUR EMERGENCY
Go to the nearest Hospital
Or call 911 for help

OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME

Activity

- Everyone reacts differently to anesthesia - You may experience dizziness or sleepiness afterwards. A **RESPONSIBLE ADULT** must be with you for **24 Hours** after surgery.
- Rest at home for 24 hours after general anesthesia or local anesthesia with sedation.
- **Do Not Drive** or operate machinery for 24 hours or as instructed by your physician.
- ☐ You may shower after _____ hours, or ☐ sponge bathe only.

Medications

- Take your prescriptions as ordered. If antibiotics are prescribed, finish the entire prescription. If you experience anything unusual such as a rash, nausea, or vomiting, notify your physician immediately. If your pain medication is not effective, notify your physician.
- Avoid driving, operating machinery or drinking alcohol when using pain medication.
- If you take daily Aspirin or blood thinners, resume per your physicians instructions.

Diet

- Avoid alcohol for 24 hours after anesthesia.
- Eat light foods that are very easy to digest and progress to a regular diet as tolerated, unless otherwise specified by your physician.

Wound Care

- Keep your dressing clean and dry. Do not remove dressing unless instructed to do so.
- Apply ice to _____ for _____ .
- Elevate _____ as instructed.
- Notify your physician regarding excessive bleeding, swelling or pain, fever greater than 101°, any unusual color changes or temperature changes to the operative extremity or if your dressing feels too tight. After surgical dressings are removed any redness, swelling or foul drainage from incision should be reported.

Special Instructions: _____

_____

_____

IF ANY PROBLEMS OCCUR, CONTACT YOUR SURGEON. A NURSE WILL CALL THE NEXT BUSINESS DAY.
IF YOU HAD YOUR SURGERY AT THE SURGICAL CENTER, YOU CAN CALL THEM BEFORE 4:30.
KEEP THESE INSTRUCTIONS BY THE PHONE SO YOU CAN REFER TO THEM.

IN THE EVENT OF AN EMERGENCY PLEASE CALL 911 OR GO TO THE EMERGENCY ROOM.

Thank You for choosing Saint Mary's Hospital.

Surgeon Telephone # _____ Follow up appointment _____

☐ Discharge patient when discharge criteria met.

TO/VO BY M.D. TAKEN BY R.N.			I have participated in the development and understand the Discharge Plan. SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:	TIME AM PM DATE / /	
SIGNATURE AND DATE	HOUSE STAFF SIGNATURE	TIME AM PM DATE / /	NURSING SIGNATURE	TIME AM PM DATE / /	
			ATTENDING SIGNATURE M.D.	TIME AM PM DATE / /	

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

NVSC NAUGATUCK VALLEY SURGICAL CENTER
160 Robbins Street
Waterbury, CT 06708

OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME

MUST BE COMPLETED PRIOR TO DISCHARGE

7493

Place Patient Label Above This Line

WHITE - MEDICAL RECORDS YELLOW - PATIENT 7493 R 4/23/12

NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

No. 5928

160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663

Name _____ Age _____

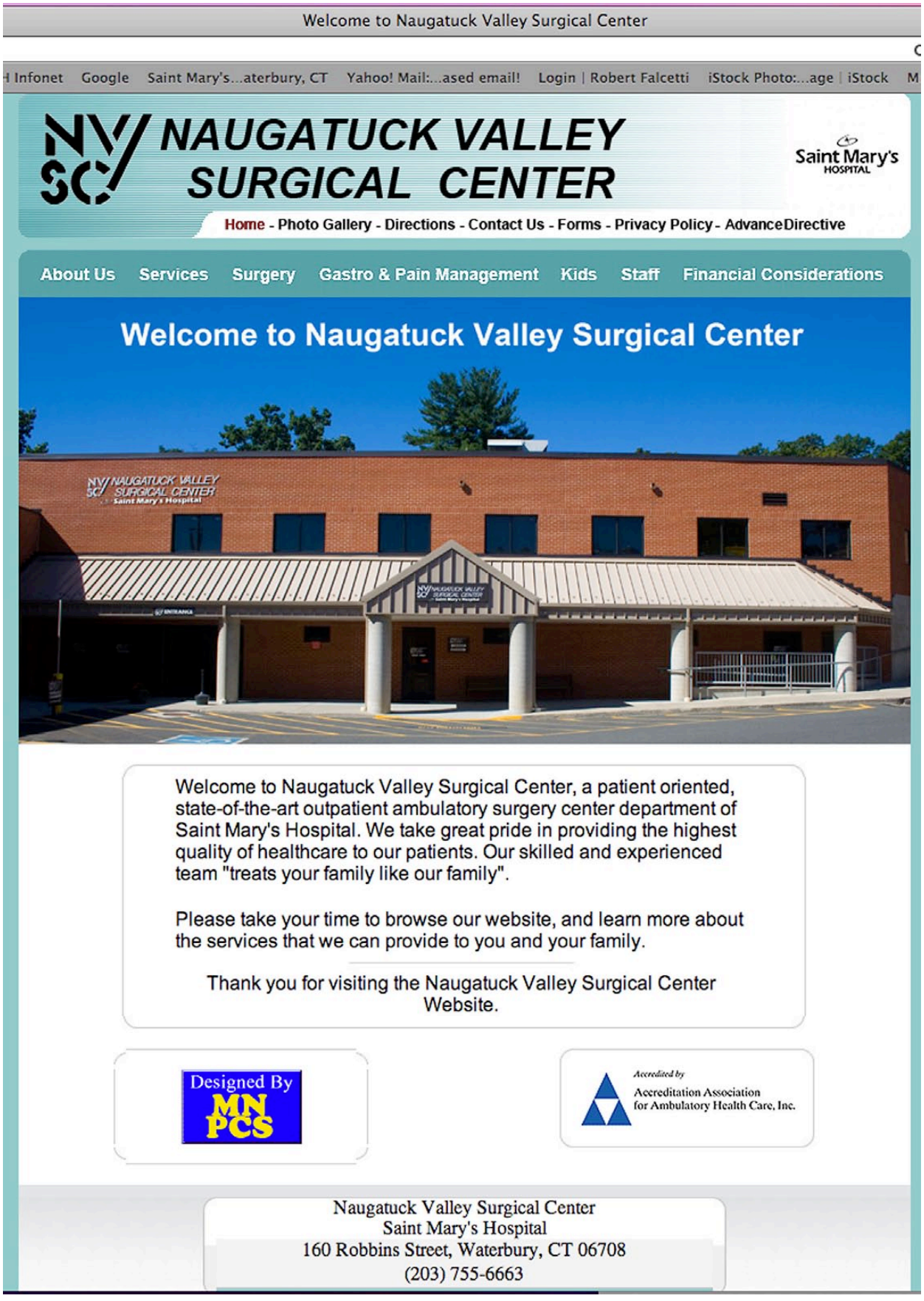
Address _____ Date _____

℞

☐ 1 -24 ☐ 25 - 49 ☐ 50 - 74 ☐ 75 - 100 ☐ 101 - 150 ☐ 150+

_____, M.D.

Refill amounts_____ D.E.A. # _____


Welcome to Naugatuck Valley Surgical Center
Infonet
Google
Saint Mary's...aterbury, CT
Yahoo! Mail:...ased email!
Login | Robert Falcetti
iStock Photo:...age | iStock
NAUGATUCK VALLEY SURGICAL CENTER
Saint Mary's HOSPITAL
Home - Photo Gallery - Directions - Contact Us - Forms - Privacy Policy - AdvanceDirective
About Us
Services
Surgery
Gastro & Pain Management
Kids
Staff
Financial Considerations
Welcome to Naugatuck Valley Surgical Center
Welcome to Naugatuck Valley Surgical Center, a patient oriented, state-of-the-art outpatient ambulatory surgery center department of Saint Mary's Hospital. We take great pride in providing the highest quality of healthcare to our patients. Our skilled and experienced team "treats your family like our family".
Please take your time to browse our website, and learn more about the services that we can provide to you and your family.
Thank you for visiting the Naugatuck Valley Surgical Center Website.
Designed By MN PCS
Accredited by
Accreditation Association for Ambulatory Health Care, Inc.
Naugatuck Valley Surgical Center
Saint Mary's Hospital
160 Robbins Street, Waterbury, CT 06708
(203) 755-6663

CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM

Thank you for choosing Saint Mary's Cardiovascular Diagnostic Center.

Here is some important information about how we bill for tests that are performed at the Cardiovascular Diagnostic Center.

I understand that I and/or my insurance provider will receive two bills.

- **One bill is for the professional services of the physician interpreting your test. Saint Mary's Hospital has partnered with Franklin Medical group to provide these professional services. If I have any question regarding the FMG bill, I can call 1-800-925-7270.**

- **The other bill is for the technical services, equipment and supplies provided by Saint Mary's Hospital personnel performing the test. The Cardiovascular Diagnostic Center is an outpatient department of Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital's bill, I can call 203-709-6428.**

Date: _____ Signature: _____ Relationship: _____

Date: _____ Witnessed by: _____

❑ PATIENT UNABLE TO SIGN _____
(INDICATE REASON)

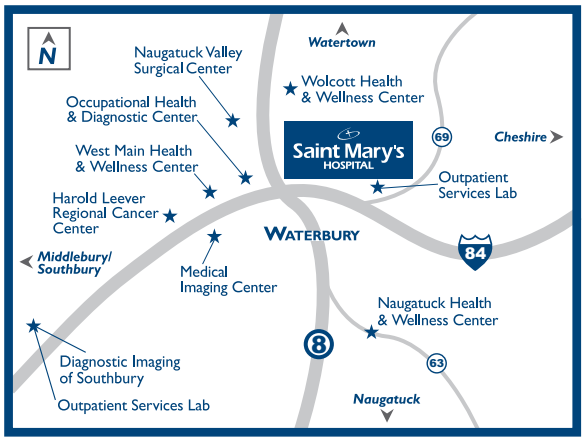
Date: _____ Witnessed by: _____

Date: _____ Witnessed by: _____

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM

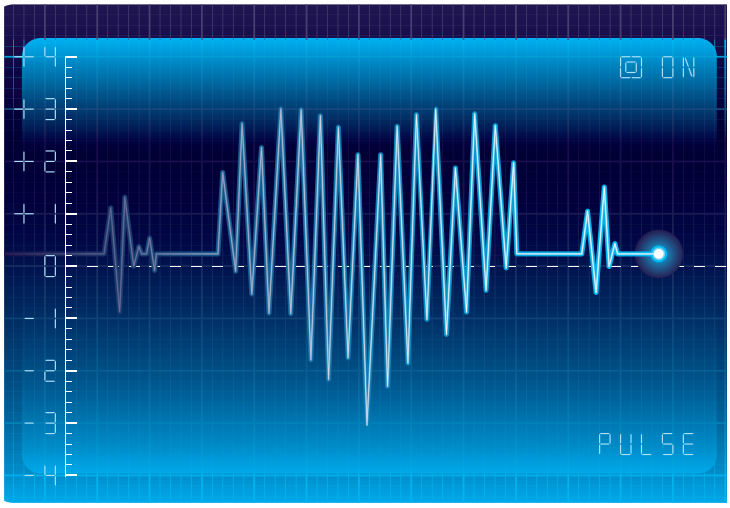
Saint Mary's Health System offers a range of convenient, quality services for patients close to home through its network of health and wellness centers.



Our center is located directly off I-84 in Waterbury with ample free parking and easy, first-floor access. Come visit us at:

1320 West Main Street
Waterbury

For appointments, call (203) 709-4506.



Saint Mary's Cardiovascular Diagnostic Center

When it comes to cardiac testing, we don't miss a beat

Saint Mary's HEALTH SYSTEM
Exceptional care. Every patient. Every day.
stmh.org

6679

Saint Mary's HEALTH SYSTEM
Exceptional care. Every patient. Every day.

Integrated Cardiac Care

at Saint Mary's Cardiovascular Diagnostic Center

The Saint Mary's Hospital Cardiovascular Diagnostic Center features state-of-the-art technology and a caring, experienced staff. As an added advantage for patients, the center is located adjacent to Franklin Medical Group Cardiology, the practice of Dr. Paul Kelly, Dr. Peter Chien, and Mary Kokoska, APRN.

The Cardiovascular Diagnostic Center offers a full range of cardiac testing services. Our highly-skilled and experienced cardiac specialists are dedicated to providing exceptional care for patients who require diagnostic testing.

Our services include:

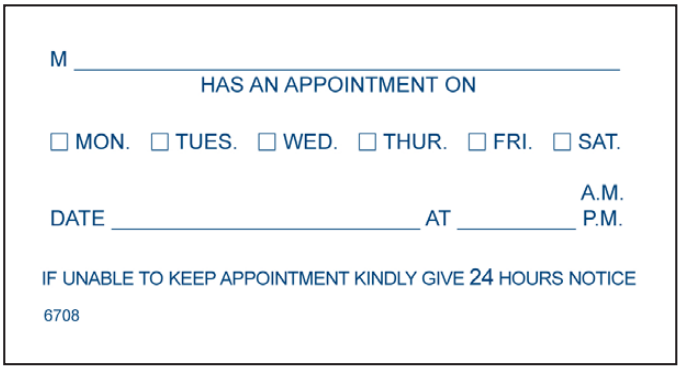
- Stress testing with nuclear imaging
- Echocardiography
- Vascular ultrasound
- Phlebotomy
- Coumadin clinic
- Arrhythmia monitoring
- Routine maintenance and monitoring of defibrillators and pacemakers

In most cases, test results are shared with referring physicians the same day. For appointments, please call **(203) 709-4506.**

Front

Saint Mary's
Cardiovascular Diagnostic Center
1320 West Main Street, Waterbury, Connecticut 06708
PHONE: 203-709-4506
FAX: 203-709-4566
www.stmh.org
A service of Saint Mary's Health System

Back


M _____
HAS AN APPOINTMENT ON
☐ MON. ☐ TUES. ☐ WED. ☐ THUR. ☐ FRI. ☐ SAT.
DATE _____ AT _____ A.M. P.M.
IF UNABLE TO KEEP APPOINTMENT KINDLY GIVE 24 HOURS NOTICE
6708

Saint Mary's Hospital, Waterbury, CT – Patient Services
Google
Popular
SMH Infonet
Google
Saint Mary's...aterbury, CT
Yahoo! Mail:...ased email!
Login | Robert Falcetti
iStock Photo:...age | iStock
MapQuest M...ion
Saint Mary's
HEALTH SYSTEM
Exceptional care. Every patient. Every day.
Home
Site Map
Contact Us
Directions
News
Portals
About Saint Mary's
Patient Services
Admission Information
Physician Services
Graduate Medical Ed.
Foundation - Ways to Give
Career Portal
Special Events
Affiliate Companies
Community Programs
Portals
Patient Services
Behavioral Health Care Services
Cardiac Care
Emergency Medical Services
Community Training Center
EMS Services Provided
Endoscopy Department
Level II Trauma
Lifeline
Medical Imaging Center
Occupational Health
Pulmonary Rehabilitation
Saint Mary's Urgent Care Centers
Sleep Disorders Center
Surgical Weight Control
Women and Children Services
The Birthplace
Children and Family Services
Growing Family Web Nursery
Maternity Pre-Admission Form
Pediatrics
Wound Healing Center
Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
(203) 709-6000

Acknowledgment of Disclosure

Saint Mary's Hospital would like to thank you for patronizing our Urgent Care Facility. We are committed to providing you and your family the best medical care possible. We ask that you read over the following information, initial the boxes and sign your name at the bottom of the page. If you should have any questions, please ask our front desk staff for assistance.

_____ I understand that the Saint Mary's Urgent Care Center is no longer a designated Walk-in Center effective November 18, 2012, and as a result of that change the level of services available has increased.

Urgent Care is the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment. As an Urgent Care Center, we can treat many problems that can be seen in a primary care physician's office, but we offer some services that are generally not available in a primary care physician's office, such as, X-Ray's, treatment of minor fractures, foreign body removal and repair of minor and moderate-severity lacerations.

_____ I understand that the physicians are not employed by Saint Mary's Hospital and that fees charged by these physicians for services provided will be billed separately and apart from the fees charged by the hospital.

_____ I understand that the physician's services will be billed by Long River Physicians.

_____ **Insured Patients:** I understand that the services being provided will be submitted to my insurance carrier as an Urgent Care charge I also understand that some insurance carriers may process this claim as an Emergency Visit and assess an Emergency Room Co-pay/Deductible.

Patient/Guarantor Signature:_____Date:_____

UCC Employee Signature: _____Extension _____

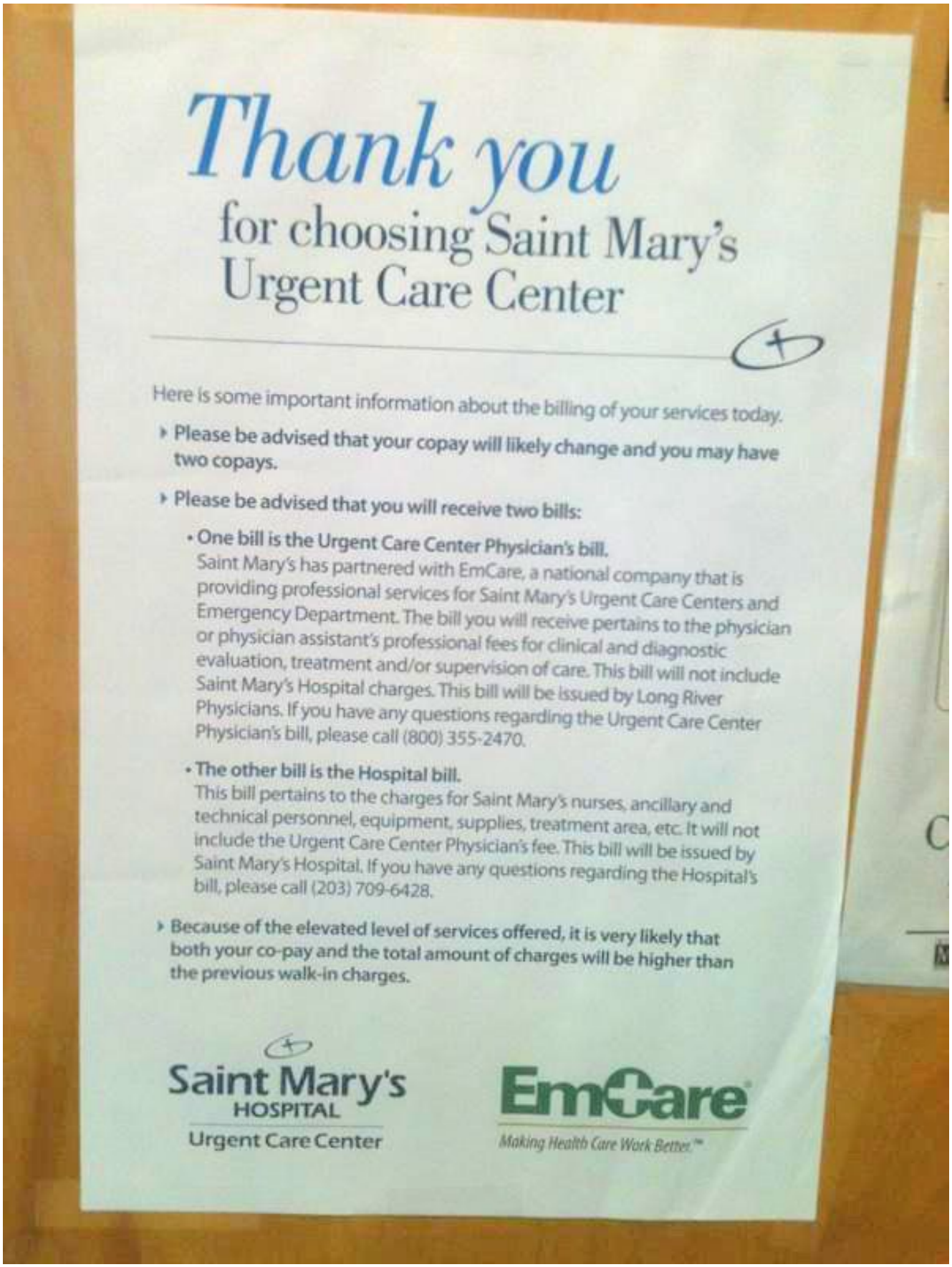
Long River Physician
100 Witmer Road
Suite 220
Horsham, PA 19044
215-442-5046

Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
203-709-6428

Saint Mary's
HOSPITAL
Urgent Care Center

Saint Mary's
HOSPITAL
Urgent Care Center
Lab / Blood Draw Hours
Monday - Friday 7:00am - 6:00pm
Saturday 7:30am - 2:00pm
Sunday 9:00am - 1:30pm
Walk-In / Radiology
Monday - Friday 9:00am - 6:30pm°°
Saturday 9:00am - 4:30pm°°
Sunday 9:00am - 1:30pm°°
°°Last Patient Registered
WARNING
STERLING

The care you need
when you need it.
Expert medical care without the Emergency Room wait
Convenient hours and parking
No appointment needed
Most insurances accepted
Saint Mary's
HOSPITAL
Urgent Care Center



Thank you
for choosing Saint Mary's Urgent Care Center

Here is some important information about the billing of your services today.

- **Please be advised that your copay will likely change and you may have two copays.**
- **Please be advised that you will receive two bills:**
  - **One bill is the Urgent Care Center Physician's bill.**
    Saint Mary's has partnered with EmCare, a national company that is providing professional services for Saint Mary's Urgent Care Centers and Emergency Department. The bill you will receive pertains to the physician or physician assistant's professional fees for clinical and diagnostic evaluation, treatment and/or supervision of care. This bill will not include Saint Mary's Hospital charges. This bill will be issued by Long River Physicians. If you have any questions regarding the Urgent Care Center Physician's bill, please call (800) 355-2470.
  - **The other bill is the Hospital bill.**
    This bill pertains to the charges for Saint Mary's nurses, ancillary and technical personnel, equipment, supplies, treatment area, etc. It will not include the Urgent Care Center Physician's fee. This bill will be issued by Saint Mary's Hospital. If you have any questions regarding the Hospital's bill, please call (203) 709-6428.
- **Because of the elevated level of services offered, it is very likely that both your co-pay and the total amount of charges will be higher than the previous walk-in charges.**

Saint Mary's HOSPITAL
Urgent Care Center

EmCare
Making Health Care Work Better.™

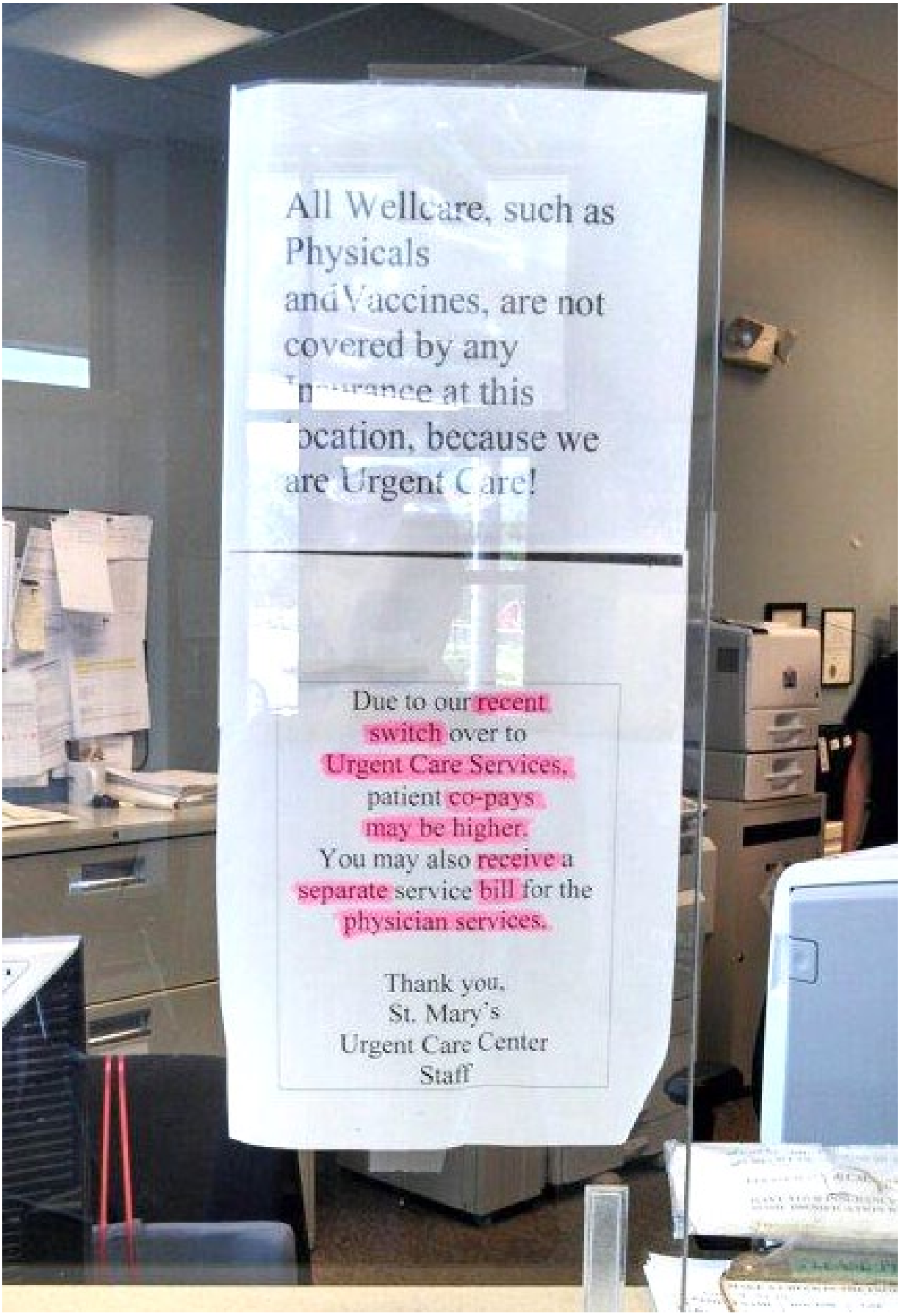

All Wellcare, such as
Physicals
and Vaccines, are not
covered by any
at this
location, because we
are Urgent Care!
Due to our recent
switch over to
Urgent Care Services,
patient co-pays
may be higher.
You may also receive a
separate service bill for the
physician services.
Thank you,
St. Mary's
Urgent Care Center
Staff

EXHIBIT 19

Saint Francis *Care's* Community Health Outreach Programs

Caring for the community beyond the hospital walls has long been a priority for Saint Francis *Care*. By bringing its services into the community through programs which focus on community health, Saint Francis is able to embrace a myriad of creative solutions for improving our community's health.

Saint Francis' commitment to community health is best demonstrated by the establishment of the Curtis D. Robinson Center for Health Equity (begun as an Institute in 2009) **:** a dedicated platform dedicated to eliminating disparities in healthcare and serving as a leader in health equity. Housed within the Urban League of Greater Hartford, this unprecedented Saint Francis Board-endorsed initiative serves as a hub for community engagement, data collection and use in understanding needs of our community, and bridging the resources of Saint Francis with all communities we serve. Here you will find a multi-cultural, multi-lingual team of physicians, nurses and outreach staff harnessing the health system resources into the identified needs of families in our service areas of Connecticut. They include culturally-appropriate health assessments, health education; community-based clinical services such as health screenings and immunizations. A key principle of the Center's activities is to be culturally and community informed. A survey, for example, indicating the health priorities of 700 African American and Latino members of the community helps give focus to health outreach activities.

Saint Francis *Care* also Saint Francis *Care* partnered with like-minded organizations such as the Hartford Hispanic Council, Tuskegee University, local area places of worship and other community organizations to focus on specific health needs of minority populations in its service area and culturally inclusive training for employees. These health equity initiatives demand a strategic approach to health equity informed by the communities we serve, our partners, and our Saint Francis' team committed to measuring impact on improved care. Hence, research, community engagement, education, and bridging health resources to those seeking care are core activities identified with the Curtis D. Robinson Center for Health Equity.

Examples of our recent successes:

- The 4th Annual Town Hall Meeting – 11/18/14 "Is Our Food Making Us Sick?" sponsored by the Curtis D. Robinson Center For Health Equity provided information to the community in the areas of food policy, nutrition, obesity, reduction and health and community organizing around health issues. The Center nurtures ongoing leadership to bring simple

solutions to complex issues that honor the many contributions needed to assure equitable health for our region.

- Saint Francis Hospital and Medical Center Breast Feeding Heritage and Pride - Saint Francis Hospital and Medical Center in partnership with the Hispanic Health Council has just received a three year grant to expand a program that trains low income African American and Hispanic mothers who are patients of the Saint Francis Center for Women's Health. Through this program women are encouraged to breast feed their newborns using trained peer counselors. The goals of this program are to reduce the risk of Sudden Infant Death syndrome, asthma, allergies, respiratory infections and other problems among newborns in this population of women. Breast feeding also provides vital nutrients for growth and development, encourages development of mouth and jaw and reinforces the mother/baby emotional bonding.
- Maternal Infant Outreach Program (MIOP) – The goals of the City of Hartford MIOP program are to monitor health conditions of high-risk pregnant women in Hartford, to assess preventable risk factors associated with low birth weight, and to help identify effective and ineffective elements of existing efforts. Saint Francis Hospital and Medical Center has participated in this program for many years. Services provided by Saint Francis include pregnancy tests, prenatal care, patient education and nutritional counseling, routine gynecologic care, breast exams, cervical cancer prevention, post-menopausal counseling and hormone therapy along with STD and HIV testing and counseling. MIOP is a system of care that is proven and has demonstrated its effectiveness through reduced infant mortality rates, lower number of babies born with low birth weights, increased number of women accessing prenatal care, higher number of women having full term babies, and more linkages and services to families.

In addition to these targeted programs seeking to address service inequities for minority populations in its service area Saint Francis Care offers a wide range of community education programs to its entire service area population. Those programs are listed below:

Caregiver Support Services

- CREC Magnet School Partnership
- Golfers in Motion Program
- Health Equity Fellowship
- Housing Support
- Joan C. Dauber Food Bank
- Keep-the-Power-On Utility Clinic programs that address underlying social problems, such as poverty, homelessness, and environmental issues.

These activities support community assets by offering the expertise and resources of the healthcare organization.

• Literacy Support Programs
• Medical Legal Partnership Program
• Nurturing Families Network Case Management Services
• Pastoral Counseling Program
• Procurement of Pharmaceuticals for Indigent Clients
• Services for Children and Families Impacted by Child Abuse
• Support for Malta Van Services Healthcare Support Services
• Support of Neighborhood Associations
• The Auxiliary Repetitions Thrift Store

Community Health Education

• Bereavement and Spirituality Classes
• Break Free from Smoking Program
• Breastfeeding Support
• Cancer Support Groups
• Cardiac Rehab and Wellness
• Care Management Support Services
• Center for Diabetes & Metabolic Care Program Education and Outreach
• Child Abuse Prevention Education and Outreach
• Childbirth Education Classes
• Colorectal Screening Program
• Community Lectures on Health Promotion, Early Detection, and Disease Management Topics
• CPR and Safety Programs
• Diabetes Support Services
• Domestic Violence Prevention Training
• Golfers in Motion
• Healthy Start and Parenting Programs
• Integrative Health Services Classes
• Lead Poisoning Prevention Education and Outreach
• Mental Health Alliance and Support
• Multidisciplinary Case Management Team for Child Abuse
• Nutrition and Weight Management Programs
• Powerful Tools for Caregivers Program
• Preventive Health Screenings:
- Bone Density Screenings
- Cardiovascular Risk Assessment
- Child Seat Safety
- Diabetes Screening
- Mammograms
- Prostate Cancer
- Skin Cancer Screenings
• Support Groups including

-Amputee Information Series
-Stroke Support Group
-Aphasia Support Group
-Spinal Cord Injury Support Group
-Living with Multiple Sclerosis
-Living with Congestive Heart Failure
-High-risk Pregnancy
-Pregnancy and Infant Loss
• Violence and Injury Prevention Program
• Women's Heart Program Outreach Community-Based Clinical Services

Other Health Improvement Services
• Access to Recovery for Substance Abuse Clients
• Adaptive Rowing Program
• Breast and Cervical Cancer Education and Outreach

EXHIBIT 20

SAINT FRANCIS Care Policy	**Title:** **Financial Assistance Policy**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Patient Accounting	**Number** ADM 060	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 11/2/2015	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital (the "Hospital") to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by the Hospital for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

SCOPE:

This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures, bariatric services and secured liens on liability cases.

Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided:
    a. Family size - as reflected on prior year tax return; and
    b. Income verification – to include one of the following:
        i. Four most current pay stubs;
        ii. A letter from employer or government agency which verifies income and previous year's tax return; or
        iii. Active Medicaid eligibility screen print that indicates current full Medicaid coverage

    If any of the above required documents are not received, the application will be pending for thirty (30) days. A written notification will be sent to the applicant detailing the missing documentation. If the missing documentation is not provided within twenty (20) days, the application will be denied. An approved application will cover all previous covered services and as well as future qualifying services for the next six (6) months.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with a verified income below 100% of the poverty guidelines. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown, the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

  Effective 1/1/2014: Un-insured applicants must complete an application through Access Health during open enrollment for eligibility determination for a qualified health plan, or HUSKY Health..

4. Eligibility is determined on family size and current income.

   a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.

   b. Patients with income levels ranging between **200% to 250%** of the federal poverty guidelines and who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

   Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

   Examples:

   - If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.

   - If the insurance payment is less than the Medicare allowed amount, the patient is responsible to pay up to the Medicare allowed amount. Any amount over the Medicare allowed amount will be adjusted with the financial assistance code 97000039 or 5017.

   - Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:

     - Reached their maximum benefits

     - Entire procedure is non covered due to limitations of their policy or diagnosis

     Patients within the 200-250% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

     Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel must determine eligibility within thirty (30) days of receipt of a completed application.

6. Assessment for other free bed funding is completed as part of the financial assessment.

PRESUMPTIVE SUPPORT:

The Hospital recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted, it is classified as "Presumptive Support." No application is required for this group.

Examples of presumptive cases include:

- Deceased patients with no known estate;
- Homeless patients;
- Patient bankruptcies;
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through religious order and
- Patients who are qualified for other State Assistance Programs that are income based.

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

<$4,999 - Customer Service Rep/Financial Counselors/Team Leads
$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from financial assistance
- Liability Cases that have secured liens are excluded from financial assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.
- Applications are approved for six (6) months.
- Patients with non-contracted insurance carriers or medically necessary non-covered services may be eligible for a discount up to 45%on a case by case review (no application required).

CROSS REFERENCES:

Self Pay Billing and AR Management Policy
Emergency Medical Screening and Stabilization/ EMTALA

APPROVED BY: Policy requires Vice President approval.

Nicole Schulz	Date:
Vice President	11/2/2015

REPLACES:

Financial Assistance Policy 1/30/2015

1

SAINT FRANCIS Care Policy	**Title:** **SELF PAY BILLING AND AR COLLECTION POLICY**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Business Office	**Number** ADM 064	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 1/30/2015	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE: It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a summarized bill including but not limited to encounter specific information including dates of service, summarized charges, discounts, payments, adjustments and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the Access Health CT, State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial assistance program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time (4 statements or 120 days) to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.
- Return mail without other non-identified information is returned, the account may to collections before 120 days.

SCOPE:

This policy applies to the Business office and hospital staff

POLICY:

Self-Pay Billing: Execution of the self-pay billing cycle.

Primary self-pay balances, those balances for which there is no insurance coverage, or self pay balances after insurance has been processed, will receive a series of four statements when the account is released from billing.. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, an account is generated and held for the appropriate min days which allows the charges to be associated with the patient encounter. After the min days are satisfied the account is moved from pre-receivable status to active accounts receivable status in the hospital's receivable system.
- Second, a statement displaying a summary of the total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Simultaneously a file containing the billed inventory is electronically transferred to a contracted self-pay customer service agent to initiate contact and work with patients for account resolution.

Each statement includes a specific message based upon the status and age of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement (payment plan) will receive an alternative self-pay dunning cycle. Payments on payment arrangements must

have consistent payment in accordance with the plan. If installment payments are missed the account is eligible for collection.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay accounts are assigned to a contracted customer service agent from the day the account is ready for billing. The contracted agent receives daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through Access Health CT, the State of Connecticut's Medicaid Assistance program, as well as St. Francis' internal financial assistance program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing consistent monthly payments for the agreed upon amount are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt and written of at the end of the month.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

Approval of bad debt accounts are as follows:

$5,000-$24,999 - Supervisor

$25,000-$49,999 - Manager

$50,000-$99,999 - Director of Patient Financial Services

>$100,000 - VP, Revenue Cycle

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above.
- Any unpaid balance in bad debt with no activity for 180 days, will be returned to the hospital and get referred for secondary placement see **AAB & LEVIN BAD DEBT RETURNS TO EOS CCA PROCEDURE**

REFERENCES:

CROSS REFERENCES: Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and AAB & LEVIN Bad Debt returns to EOS CCA procedure.

APPROVED BY: Policy requires Vice President approval.

Vice President(s):	Date:		Date:
Nicole Schulz Vice President Revenue Cycle	1/30/2015		

REPLACES:

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11; 07/29/2011; 5/22/2013, 2/6/2014;

EXHIBIT 21

A Community Health Needs Assessment

Department of Health and Human Services

March 2012

Healthy Hartford

The mission of the Hartford Department of Health

and Human Services is:

To protect the well-being of the people in Hartford, to promote an environment conducive to healthy lifestyles, and to prevent adverse health outcomes. Whenever possible, the Department will endeavor to employ strategies, policies and interventions through community partnerships to reduce health disparities.

A Community Health Needs Assesment

Hartford Department of Health and Human Services

This report is funded in part by:

Hartford Hospital

Connecticut Children's MEDICAL CENTER

SAINT FRANCIS Hospital and Medical Center

Acknowledgements

Community Health Needs Assessment Consortium
City of Hartford Department of Health and Human Services
Connecticut Children Medical Center
Hartford Hospital
Saint Francis Hospital and Medical Center
University of Connecticut Health Center

Under the direction of the Community Health Needs Assessment Consortium, the Community Health Needs Assessment Workgroup began planning this assessment in early 2010. Much thought was put into creating a process and document that would be both useful and enlightening to healthcare organizations, community-based health and social services organizations, and the community at large. The City of Hartford Department of Health and Human Services wishes to thank our community health needs assessment partners for their generous support to this project and to their designated representatives on the Community Health Needs Assessment Workgroup for their professional contributions and collaborative efforts throughout the study process. Special thanks go to the Urban Alliance for providing data, analysis, and review of the Hartford Survey Project: Understanding Needs and Service Opportunities.

We would also like to thank Holleran Consulting LLC for their expertise in community health assessments and for preparing the community profile. This document has been produced for the benefit of the community. The City of Hartford Department of Health and Human Services and its community health needs assessment partners encourage use of this report for planning purposes and are interested in learning of its utilization. We would appreciate your comments and questions, which may be directed to the City of Hartford Department of Health and Human Services by phone at (860) 757-4700.

The report, as well as the raw data used to generate our findings is available for download at: http://hhs.hartford.gov.

City of Hartford
Department of Health & Human Services
131 Coventry Street
Hartford, CT 06112

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The goals of this CHNA are:

- To provide a baseline measure of key health indicators
- To inform health policy and health strategies
- To provide a platform for collaboration among community groups including schools, businesses, policy makers, and others to impact current health status
- To act as a resource for individuals, agencies, and institutions looking to identify community health needs and priorities
- To establish benchmarks and monitor trends in health status of Hartford residents
- To assist with community benefit requirements as outlined in the PPACA

The information included in the CHNA provides the foundation upon which community health programs and interventions can be targeted, developed, and evaluated with the ultimate goal of improving the health of the community and its members.

II. Summary of Key Findings

Social Determinants – Many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings in the secondary data profile point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. The Key Informant interviews, the Hartford Survey Project, and data from the Health Equity Index validate the concern for marginalized and underserved populations.

- The top 5 quality of life issues mentioned by Key Informants as currently having the most negative impact in Hartford were **poverty**, **job opportunities**, **quality of housing**, **neighborhood safety**, and **education**.

- Hartford has a greater number of renters than owners, more households with mothers being the sole head of household, and lower residential property values than the state, overall. These are associated with poor health outcomes. There is also a higher rate of service occupations when compared to the state and nearly 1/5 of the city's labor force unemployed. With subpar housing and employment levels, overall economic security rates low.

- Nearly a third of Hartford's adults do not have a high school diploma, and the average graduation rate is 77%; high educational attainment is one of the key determinants of community health since it leads to increased economic security and occupational prestige.

- More than 10% of all of the crimes committed in Connecticut in 2009 were committed in Hartford, even though Hartford accounts for less than 4% of Connecticut's population, and there are certain types of crimes that occur with greater frequency in Hartford than in the state overall.

- Compared to other Connecticut cities, the overall environmental quality in Hartford is poor; HEI scoring for waste stream and water discharge pollutants were low. The underlying perception of the city as "unclean" could also impact individual health decisions.

- Less than half of Hartford's residents are registered to vote; a trend that is often associated with fewer community resources and support networks.

Health Indicators

Cancer incidence for all types (specifically lung and prostate) is well below the national and state levels; however, it is important to keep in mind that Hartford has a relatively young population when compared to state and national figures. Key Informants also perceived cancer as less of a priority with only 11.9% respondents ranking it within their top five health issues.

- In general, chronic lower respiratory disease death is lower in Hartford than across the nation or in the state; however, asthma hospitalization rates in Hartford are much higher when compared to the state, with children and adult rates that are at least three times higher than the state rate. Asthma, not one of the options provided in the Key Informant survey, was the most frequently written-in health issue by participants.

- Although one of the top health issues identified by Key Informants was violence, most respondents perceive that violent acts, while isolated in Hartford, are a product of a depressed economic situation. Hartford accounts for more than a third of all murders in the state, and experiences a higher percentage of assaults. This disproportionate and avoidable indicator negatively impacts the overall quality of life in the city.

- There is a much younger population in Hartford compared to the state and nation that is reflected in the mortality rate. This is also reflected in a lower occurrence of the top ten national causes of death, which are often age-related. However, the much higher age-adjusted rate suggests that the elderly population, albeit small, is dying at a very high rate. Infant and neonatal death rates are much higher in Hartford than the state and nation. Hartford also has considerably higher rates of infectious/communicable diseases than the state.

- There is an indication that obesity is a concern for Hartford. Health indicators for heart disease are worse for Blacks and Hispanics, and those who live below the poverty threshold; diabetes rates in Hartford have been increasing in recent years.

Access to Care – Access to care was commonly cited in both the Key Informant study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

III. Methods: How We Obtained the Data

The data in this report were compiled from a variety of resources, and includes both quantitative and qualitative data. Additionally, it includes very specific information on critical health indicators and broader information regarding the social determinants of health.

The CHNA report synthesizes findings and data from the following three sources:

Key Informant Interviews – Each Workgroup member identified 5 to 10 people in management or leadership positions with various community organizations including health and human services, religious organizations, and government agencies; 85 unique Key Informants were identified by the Workgroup. Respondents were asked to critically evaluate health needs pertinent to the community through their experience. Survey questions focused on underserved populations and access to care issues in Hartford. In total, 59 interviews were conducted; see Appendix for a complete list.

The Hartford Survey Project – In order to better understand Hartford's human service needs and barriers to receiving services, a face-to-face survey conducted by the Urban Alliance was completed between October 2010 and January 2011. 402 resident surveys were completed at 12 locations throughout the city to promote geographical and ethnic diversity among respondents; these locations included grocery stores, pharmacies, and community events and programs. Respondents were asked if they would benefit from any of 12 service areas, the possible barriers to obtaining these services, and which three areas of the 12 have a need for additional services. In addition, they were asked to rank the top three service areas in Hartford that they believed were in most need.

Of the total respondents, 57% were female and 43% were male. The ethnicity breakdown was 39% African American, 37% Latino, 9% white, and 8% West Indian. Age categories for respondents were 27% between 18 and 29 years old, 42% between 30 and 49, 24% between 50 and 64, and 6% were 65 and older.

Secondary Data – Holleran, in coordination with HHS, prepared the initial community profile for Hartford from secondary data sources. In addition the following sources of data were used throughout this assessment:

- Connecticut Department of Public Health Vital Statistics and Health Outcomes
- Women's Health Quick Health Data Online via the Office on Women's Health (US Department of Health and Human Services)
- Health Data Interactive via the Centers for Disease Control and Prevention
- Connecticut Labor Market Information via the Connecticut Department of Labor

There was also an analysis of local, state, and national 2009 U.S. Census Bureau data collected via the annual American Community Survey; this data is available via the Census Bureau's website.

HHS was also able to use the Connecticut Health Equity Index (HEI) to build upon and enhance the findings from the original information. Developed by the Connecticut Association of Directors of Health (CADH), a non-profit membership organization that represents local directors of health departments and/or districts in the state, the HEI can be used to identify social, economic, and environmental conditions and their correlations or relationships to specific health outcomes. Key social determinants of the HEI include: civic involvement, community safety, economic security, education, employment, environmental quality, and housing. Collectively, these social determinants form the fabric of social and economic opportunity and a healthy environment, as well as provide insight to how social determinants may affect health outcomes and health care services of various populations living in the area of interest. The HEI is an excellent tool for determining how social factors are associated with community health, and by using up-to-date data sources, HEI's commitment to quality improvement evolves along with Connecticut's communities.

Hartford is one of three pilot sites in the state that was selected to test and evaluate the HEI for its use in mobilizing a community, stimulating sustainable action, increasing knowledge of health equity concepts and their application, and prompting structural changes that reflect local needs. Data collection for the HEI began in 2007 and continues through 2012. The HEI is based on a ten-point measurement scale, where 1 is a low score, which represents a less favorable community condition or health outcome, and 10 is a high score, which symbolizes a more favorable community condition or health outcome.

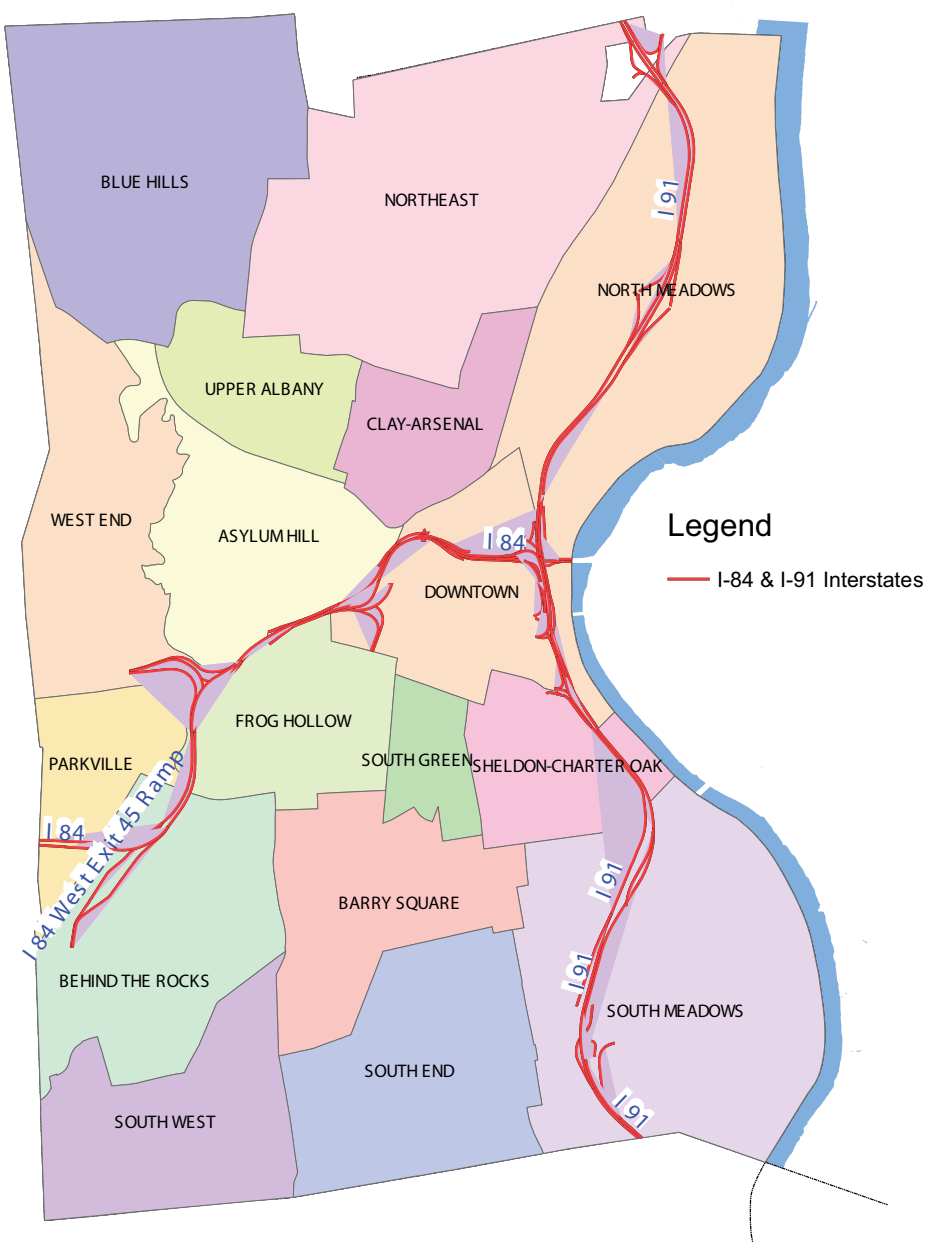
HEI maps were used to compare neighborhoods by social determinant or health outcome indicators. This comparison includes both the North Meadows and South Meadows neighborhoods for analysis, although the former is mainly comprised of car dealerships and landfill, and the latter with a small airport, a water pollution plant, and various commercial and industrial businesses. Together, both neighborhoods are home to less than 3% of Hartford's total population and must be considered when viewing the maps.

A feature of the HEI is that for every social determinant listed (civic involvement, community safety, economic security, education, employment, environmental quality, and housing), the varying factors used to determine the indexing are analyzed with each of the health outcomes in the index (accident/violence, cancer, cardiovascular, childhood illness, diabetes, health care access, infectious disease, life expectancy, liver disease, mental health, prenatal care, renal disease, and respiratory illness). Strength correlations are derived using Spearman's rank correlations, and are generated between the social determinant selected and significant health outcomes. The strength of a correlation is measured between 0 and 1, and the closer the coefficient is to 1 the stronger the correlation between the measures; a correlation of 0

signifies no statistical relationship between measures. Direction of a correlation is measured by signaling a correlation as positive or negative. A positive correlation signals a direct relation between two measures, while a negative correlation signals an inverse relationship. All correlations generated by the HEI are statistically significant.

The maps displayed throughout this report use a color gradient to indicate how Hartford neighborhoods rank with each other with regard to a specific social determinant or health indicator; the darker the color means the lower the rank. The subsequent map is a legend for all Hartford neighborhood names and should be referred to for neighborhood identification.

Map 1. **City of Hartford and Neighborhoods**



IV. Demographics

Hartford is the capital of the State of Connecticut and the seventh largest city in New England. At almost 400 years old, Hartford is one of the oldest cities in the country and at one point was one of the wealthiest. Still rich with history, it is home to the oldest public art museum and oldest public park in the nation. Starting in the late 1950s, many of the city's residents began moving to the suburbs, possibly accelerated by the construction of two major interstate highways intersecting within the city. And even though the metropolitan area ranked 32 out of 318 nationally in total economic production (second behind San Francisco in per capita economic activity) and the sixth lowest poverty rate of all Metropolitan Statistical Areas (metropolitan statistical area is a geographical region with a relatively high population density at its core and close economic ties throughout the area) for the 2010 census, the city itself remains one of the poorest in the nation; 31.9% of all its residents, and 38.3% of its families with children under 18 years old are living below the poverty line.

The population in Hartford is 124,775, with a **gender** ratio close to state and national ratios of 49% male and 51% female. Hartford is proportionally younger than the state and the U.S., which impacts numerous aspects of health including rates of some types of cancer, violence, and levels of unintended injury.

Table 1. **Age Categories for Hartford, Connecticut and the U.S.**

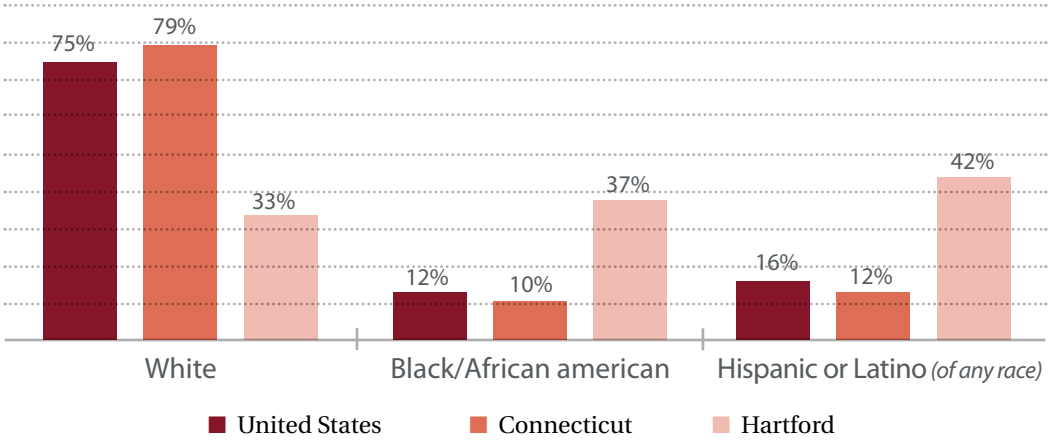
	HARTFORD	CT	US
0-19 years	**34%**	26%	27%
20-44 years	**37%**	32%	34%
45-64 years	**20%**	28%	26%
65 and older	**10%**	14%	13%

The **ethnic composition** of Hartford is mostly a mix between Hispanic/Latino of any race, Black/African American, and white. Hartford's white population is at a lower ratio than the U.S. and state while the proportion of Black and Hispanic/Latino residents is significantly higher. Ethnic variation in cultural norms, English comprehension, and beliefs about health impact the mode of health care delivery and how patients respond to health care services. This variation creates a need for increased awareness and sensitivity among service providers.

A significant percentage of Hartford residents can trace their heritage to Puerto Rico and the West Indies; in the 1940s, many immigrants from these areas moved to Connecticut to work in tobacco fields. 78% of Hartford's Hispanic/Latinos self-reported to be Puerto Rican in the 2010 census. Typically, West Indians are grouped with "Black/African American" in census data, which makes it difficult to highlight cultural differences. However, it is important to

note that the ethnic landscape in Hartford is changing as a greater number of families and individuals from Eastern Europe, Africa, and Southeast Asia continue to make Hartford their home.

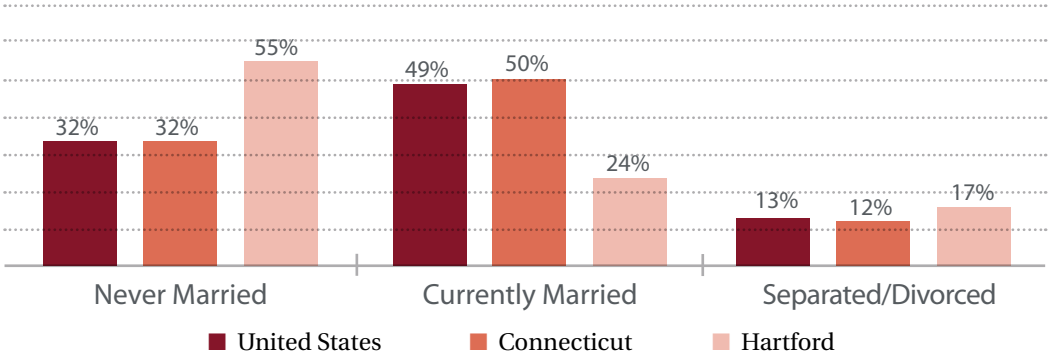
Figure 1. **Ethnic Composition for Hartford, Connecticut, and the U.S. (2009)**



This ethnic breakdown impacts the primary **language spoken** at home. The percentage of Hartford's population who only speak English is 52%, which is lower than a state and the nation comparison. Additionally, approximately 35% of Hartford residents speak a language other than English; the high percentage of non-English speakers could pose a barrier for access to all kinds of health promoting opportunities.

With regard to **marital status**, Hartford's population has a notably larger percentage of people who have never been married when compared to the state and the nation; the City of Hartford also has a smaller comparative percentage of people who are currently married and not separated. The data regarding separated/divorced residents and widowed residents are similar to state and national averages; however, the rate of legally separated couples (de facto separation while remaining legally married) in Hartford (5%) is twice that of the nation (2%).

Figure 2. **Marital Status Statistics for Hartford, Connecticut, and the U.S. (2009)**



VI. Social Determinants of Health

Quality of life issues are indicators that include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging [2]. During this assessment, Key Informants were asked a variety of questions about quality of life in Hartford. For nearly all quality of life questions, 50% or more of informants ranked them as "Poor" or "Very Poor."

Table 2. **Poorly Rated Quality of Life Measures by Key Informants**

QUALITY OF LIFE	RATED "POOR" OR "VERY POOR"
Poverty	93.1%
Job opportunities	87.3%
Quality of housing (affordable, in good condition)	72.4%
Neighborhood safety	71.9%
Schools/education	65.5%
Clean, litter-free neighborhoods	63.1%
Road/traffic conditions	53.6%
Availability of recreational activities	52.6%
Availability of care for children	31.6%
Water or air pollution	26.4%

This information provides insight for those who are regularly involved in the health and human services sector. The following section will addresses social determinants of health, and how Hartford rates relative to state and national figures.

Housing

Adequate housing provides shelter and comfort to its inhabitants, both of which impact overall well-being. One of the measures used to evaluate the association of housing and health is the number of subsidized housing units per 1000 local residents as defined by the Connecticut Housing Finance Authority. Using 2005 data, the HEI correlated housing strongly with infectious disease in Connecticut, and Hartford received the overall lowest housing score in the HEI when compared to the rest of the state.

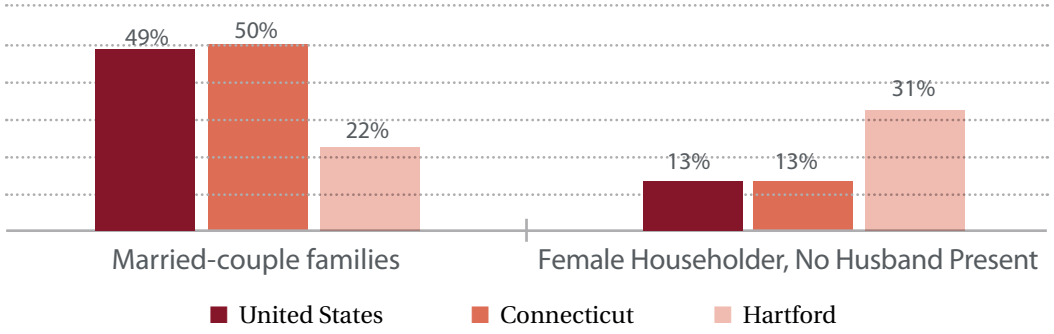
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia and/or gonorrhea, asthma hospitalizations, infectious and parasitic diseases, homicides, drug-induced deaths, mental health hospitalizations, and births not receiving prenatal care in the first trimester.

A cursory analysis of **housing occupancy** in Hartford reveals that the city has over 44,000 occupied housing units of which 26% are owner-occupied; the state average is 69%. A higher rate of rental units is associated with poorer quality of housing and impacts health. Over 70% of Key Informants surveyed ranked housing quality at either "Poor" or "Very Poor." Further highlighting the housing issue, homelessness was the issue recognized as most in need of additional services by those surveyed by the Urban Alliance (45%).

Lower residential property values, accompanied by lower sales prices and a greater number of foreclosures are strongly associated with lower quality neighborhoods. Neighborhoods with these negative housing characteristics typically have higher crime rates, lower quality school systems and a poor physical environment (sidewalks, parks and properties). For 2010, the average assessed residential property value in Hartford was $43,689, which is significantly lower than the state's average value of $209,025; and the average sales price of an existing home was $164,462, which is lower than the state's average home sales price of $288,948.

Hartford **household statistics** for family (59%) and non-family households (42%) are similar to state and national rates, but deviate substantially for the percentage of female householders with no husband present (much higher than state and national) and the percentage of married-couple families (much lower than state and national). Additionally children in Hartford are almost three times as likely (19%) than those in the rest of Connecticut (7%) to live in households with no husband present.

Figure 3. **Household Types for Hartford, Connecticut, and the U.S. (2009)**



In the HEI, Hartford has a housing indexed score of 3, which is a less favorable condition in this category. Some of the calculating factors used to determine this score are rental vacancy rates as a percentage of rental units, owner occupied housing as a percentage of total housing units, and median gross rent as a percent of household income. These measures were calculated using data from the 2000 US Census.

Table 3. **Health Indicators Related to *Housing***

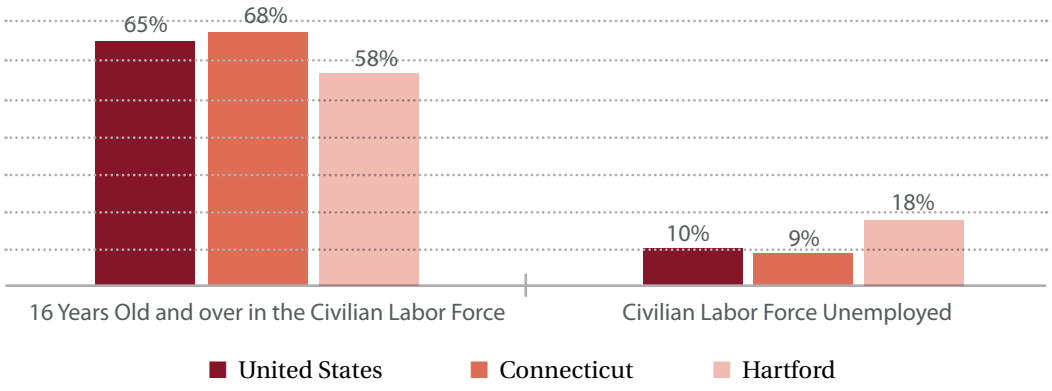
	HEI INDEX	CORRELATION COEFFICIENT
Infectious Disease	2	0.55
Health Care Access	2	0.47
Childhood Illness	1	0.42
Accidents/Violence	3	0.40
Mental Health	2	0.37
Renal Disease	2	0.33
Life Expectancy	3	0.31
Cardiovascular	3	0.29
Respiratory Illness	4	0.29
Diabetes	3	0.24
Perinatal Care	3	0.22
Liver Disease	2	0.20
Cancer	5	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Employment

As of September 2011, Hartford's unemployment rate was 15.6% according to the Connecticut Department of Labor's Labor Force Data, which is nearly twice the rate as the United States (8.8%). Against this backdrop, it is fitting that surveyed residents of Hartford rank job training/employment assistance as one of the top three service needs in the community. Key Informants had a similar view with 87% ranking job opportunities in Hartford as "Poor" or "Very Poor."

Figure 4. **Employment in Hartford, Connecticut, and the U.S. (2009)**



The percentage of workers in Hartford in management, professional, and related occupations (21.1%) is smaller than the state and nation (40.3% and 35.7%, respectively). Conversely, the percentage of those in the labor force with service occupations is much higher in Hartford

(34.4%) than across Connecticut and the nation (17.3% and 17.8%, respectively). With this disproportionate representation of Hartford residents across these occupational groups and the strong correlation between employment and health care access, one can see how Hartford struggles to maintain a healthy community profile.

Table 4. **Health Indicators Related to *Employment***

	HEI INDEX	CORRELATION COEFFICIENT
Health Care Access	2	0.54
Childhood Illness	1	0.48
Accidents/Violence	3	0.37
Life Expectancy	3	0.35
Respiratory Illness	4	0.28
Infectious Disease	2	0.28
Cardiovascular	3	0.28
Perinatal Care	3	0.26
Mental Health	2	0.23
Cancer	5	-0.19

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

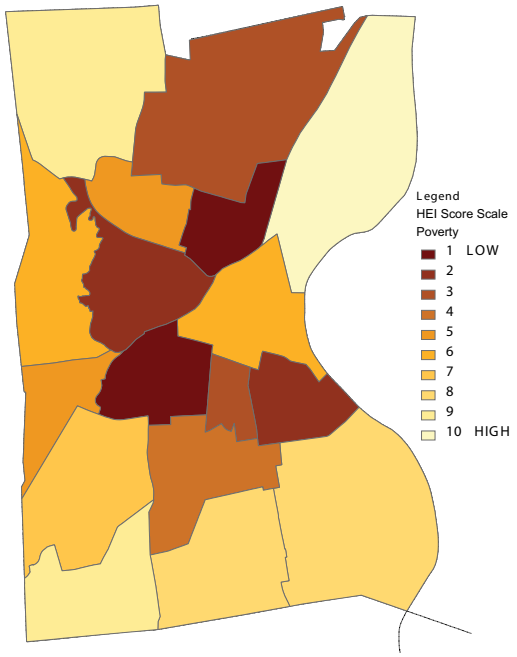
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

Economic Security

Hartford received the lowest possible score on the HEI for the majority of factors that determine economic security. Additionally, 93% of Key Informants rated Hartford's poverty level as either "Poor" or "Very Poor" on the Quality of Life section of the survey. Results from the Urban Alliance survey were similar, with employment opportunities and financial assistance topping the list of services needed. According to a report from the Robert Wood Johnson Foundation, income and educational attainment are the two most commonly used markers of socioeconomic status or position in the United States [3]. Both are strongly related measures of health and health-related behaviors. These factors can influence health through the direct effects of extreme poverty (such as malnutrition or exposure to extreme heat or cold) as well as health effects due to chronic stress; these can include the triggering and exacerbation of depression and cardiovascular disease [4].

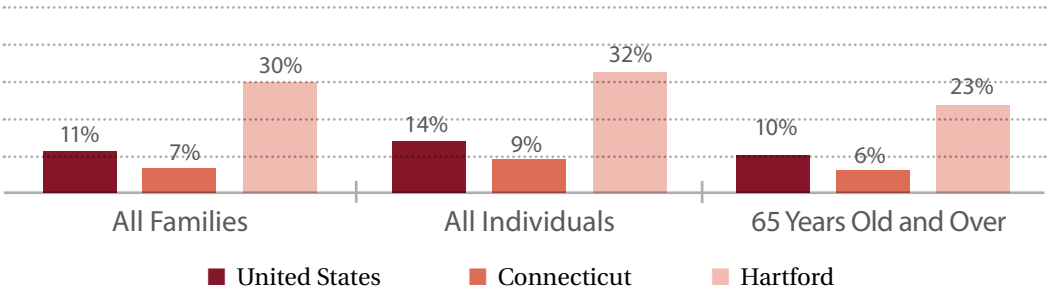
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

Map 2. **HEI Poverty Score by Neighborhood**



With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. Similar patterns have been documented for residents and for those over the age of 65.

Figure 5. **Poverty in Hartford, Connecticut, and the U.S. (2009)**



The **income statistics** for Hartford illustrate that the median income per household and family, are significantly less than the state and national figures.

Table 5. **Income Statistics for Hartford versus State and Nation**

	HARTFORD	CT	US
Median Household	**$28,300**	$67,034	$55,221
Median Family	**$33,805**	$83,069	$61,082

In Connecticut, living in poverty is correlated with higher rates of chlamydia and gonorrhea, trauma-related hospitalizations and ED visits, mental health ED treatments, homicide, hepatitis C, diabetes, drug and alcohol induced deaths, low and very low birth weight babies, and infectious and parasitic diseases.

Education

Just as low levels of employment impact community health, so does low educational attainment. 13.9% of Hartford residents perceive education to be one of the top three needs for the community. Key Informant survey respondents noted that the best way to promote wellness and prevention of illnesses in Hartford residents is through education. One respondent noted that starting with school-age children is the best way to achieve these goals. Another declared that it is necessary to tailor the education to "racial, cultural and other different types of understandings to get to the people of the city," and that the frequency of wellness education should be "not just doing it once a year" in order to convey necessary concepts.

Results from the Connecticut Mastery Test and Connecticut Department of Education were used to establish a connection to community health, as indicated in the following table:

Table 6. **Health Indicators Related to *Education***

	INDEX SCORE	CORRELATION COEFFICIENT
Childhood Illness	1	0.73
Life Expectancy	3	0.64
Infectious Disease	2	0.59
Health Care Access	2	0.57
Accidents/Violence	3	0.55
Cardiovascular	3	0.51
Mental Health	2	0.42
Respiratory Illness	4	0.41
Renal Disease	2	0.39
Diabetes	3	0.38
Perinatal Care	3	0.34
Liver Disease	2	0.21

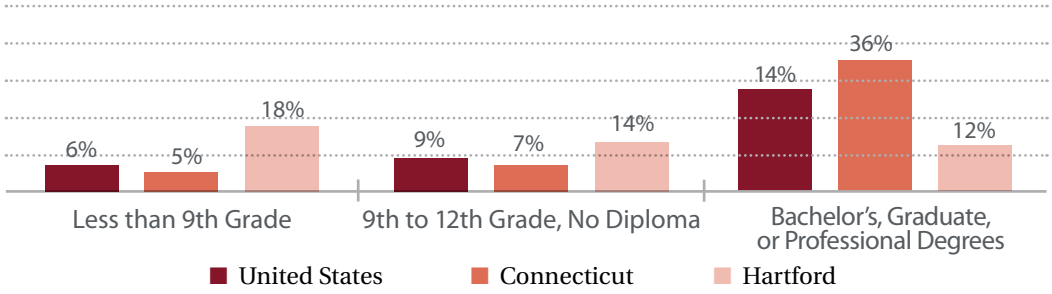
Note: All shown correlations are statistically significant and ranked in order from strong to weak.

As the demographic data indicates, Hartford residents are less likely to graduate from high school and are less likely to obtain post-secondary education when compared to the state or nation as a whole. The strong correlations suggest that a higher educational attainment leads to better health throughout an individual's lifespan, and better health and education enable people to realize their capabilities to be productive members of society [5], with greater potential for positively impacting the community.

In Hartford, low rates of educational attainment are coupled with lower standardized test scores and less frequent renovations of the city's public school facilities; according to the Connecticut State Department of Education's Connecticut Education Data and Research (CEDaR) website, the average number of years since a major renovation for Hartford's elementary, middle, and high schools is 25.8, 33.8, and 17.5 years, respectively. As indicated in the table above, education is correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, diabetes, and infectious diseases; poorer cardiovascular health; and frequency of accidents and violent incidents. Other correlations to education include lower life expectancy, lower rates of perinatal care and health care access, and worse mental health outcomes.

Over 30% of Hartford's adults of 25 years and older do not have a high school diploma, which is significantly higher than the 12% for the state. Conversely, the percentage of Hartford's population with a bachelor's degree or higher is also lower than both state and national figures at 12% when compared to 36% for the state. When these data are examined more closely it becomes clear that the problem of low **educational attainment** begins early for many, with 18% of Hartford residents over age 25 having less than a 9th grade education and another 14% having attained from 9th and 12th grade but without a diploma.

Figure 6. **Educational Attainment of Adults 25 Years and Older for Hartford, Connecticut, and the U.S. (2009)**

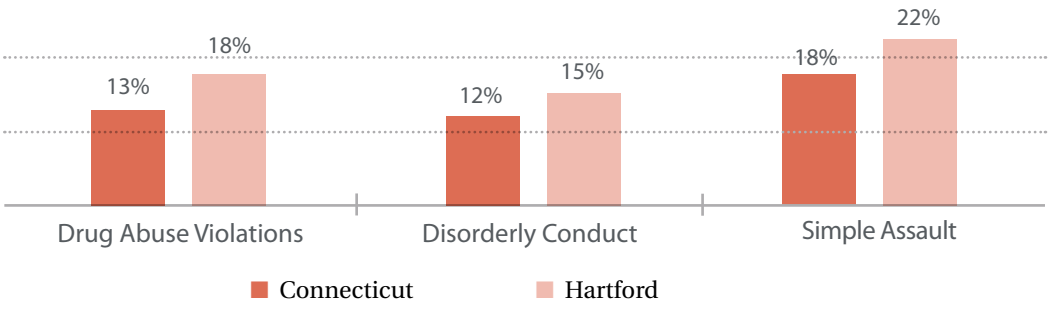


Community Safety

The HEI measures community safety by the rate of crimes against persons or property published by the 2004/2005 Connecticut Uniform Crime Reports, and within this framework Hartford receives the lowest score of 1 indicating high rates of crime. However, the crime statistics found in the Secondary Data Profile are potentially inconclusive because a high

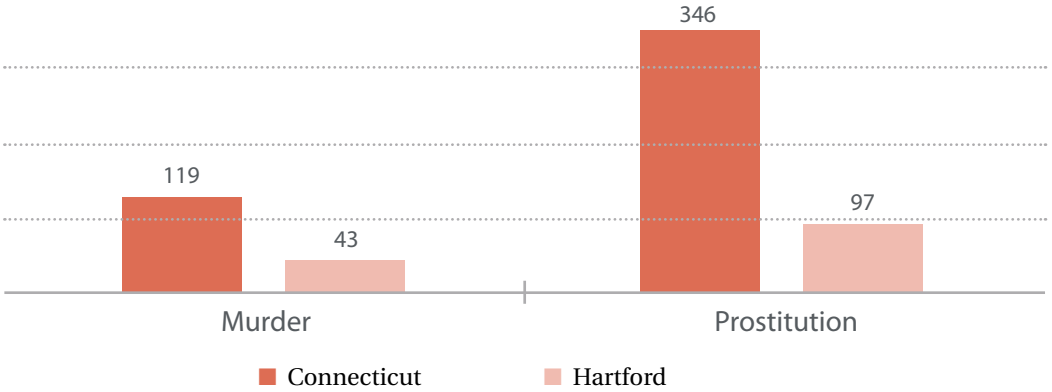
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in Connecticut occurred in Hartford. Moreover, almost 20% of the state's drug abuse violations occur in the city. Other violent crimes that occur more frequently in the Hartford than in the state are simple assault and disorderly conduct.

Figure 7. **Percent of All Crimes in Hartford and Connecticut (2009)**



Over 70% of Key Informants rated neighborhood safety in Hartford as "Poor" or "Very Poor." Given the opportunity to define a healthy community, one Key Informant stated that it should be "a community where individuals and families would choose to live [and one that can] provide a quality of life that is safe and engaged. People are being physically healthy, not being subject to lead poisoning and toxic things. Violence and noise pollution are not issues." Unfortunately, this community scenario is not widely available for the majority of Hartford residents, but community safety has multiple measures and Hartford experienced proportionally less crime than the state on infractions involving larceny/theft, gambling, liquor laws, and driving under the influence.

Figure 8. **Crime in Hartford and Connecticut (2009)**



In 1982, Wilson and Kelling introduced the broken windows theory to explain urban disorder and vandalism on crime and anti-social behavior [6]. The appearance of the environment can suggest what is acceptable, with a disordered environment implying that behaviors that are usually unacceptable can be perpetrated without fear of consequences. And although this theory has been met with criticism cities such as New York and Albuquerque have implemented policy shifts to address "quality of life" issues and have seen improvements in the overall community security and decreases in crime. Generally speaking, a safer community is synonymous with a healthier community.

Hartford has taken strides to address its issue with violence in the city. Since the re-instatement of the Shooting Task Force in 2011, shootings have decreased by 35% [7]. Although the partnership with neighboring cities, the Connecticut State Police, and the Office of the Attorney General has been effective in reducing shootings, a more comprehensive approach in crime intervention is needed. The City of Hartford is also making a concerted effort to improve the condition of its neighborhoods through the implementation of the Livable and Sustainable Neighborhoods Initiative. As part of this initiative, city government is partnering with homeowners and other neighborhood stakeholders throughout the city to address blighted properties and revitalize Hartford's sense of community. By addressing the needs of some of Hartford's most vulnerable areas, the city is taking proactive steps to rebuild its infrastructure, reduce crime, and restore hope.

Environmental Quality

The environment where we live, work and play; the quality of the air we breathe; the water we drink – all of these have an impact on our health. While individual education and behavior change are important to improving health, the real power in making progress on health is in changing the environment and systems that structure and affect our world.

The HEI measures the relative environmental burden of Connecticut's municipalities by using specific Federal Toxic Release Inventory data, examining levels of locally generated air and water pollution, and industrial density. These two measures are positively correlated with employment opportunities; however, they are however negatively correlated with health outcomes. Hartford receives an average score (4) in the Health Equity Index for both the number of facilities reporting and the total air emissions in pounds. Total water discharge and waste stream in pounds, measures of water pollution, are strong indicators of localized pollution levels, and Hartford has high levels of both. These two measures strongly correlated with the chlamydia and gonorrhea rates.

While potential relationships between high STD rates and a high environmental burden may initially seem attenuated at best, both act as a highly reliable indication of a marginalized neighborhood impacted by blighted property and compromised opportunities for fulfillment. Strong correlations between two seemingly distinct and independent realms such as environment and STDs speak to the vast array of various social and health burdens underserved communities bear disproportionately.

Civic Involvement

According to the HEI, Hartford receives the lowest possible score in terms of civic involvement. Civic involvement impacts health because it is a direct measure of social equity, activism and sustainability of a community; the HEI indicates a strong correlation of low civic involvement with infectious diseases, accident/violence, childhood illness, and life expectancy.

Table 7. **Health Indicators Related to *Civic Involvement***

	INDEX SCORE	CORRELATION COEFFICIENT
Infectious Disease	2	0.59
Accident/Violence	3	0.57
Childhood Illness	1	0.51
Life Expectancy	3	0.50
Mental Health	2	0.45
Cardiovascular	3	0.42
Health Care Access	2	0.42
Liver Disease	2	0.33
Renal Disease	2	0.32
Respiratory Illness	4	0.31
Diabetes	3	0.29
Perinatal Care	3	0.29

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Communities with demonstrated social cohesiveness are more likely to have greater resources and support networks, which would allow for improved health outcomes. Approximately 45% of Hartford's adult residents are registered to vote indicating that an inadequate proportion of the community selects state and municipal government officials. Several factors may prevent an individual from registering to vote including a lack of motivation, frustration with current leaders, or language or cultural barriers. In order to increase the number of registered voters, community-based education initiatives should be employed and should focus on demonstrating to individual residents that they are valued members of the community, and that their vote does in fact make a difference.

Community Food Security

Although not identified as a social determinant of health within the HEI, food security plays a vital role in urban settings like Hartford. While there are 14 medium and large grocery store retailers in the city, corner markets, convenience stores, and fast-food outlets are far more abundant, making a healthy diet difficult to maintain. Pre-packaged and prepared foods are more readily available at such establishments, and their lack of fresh and healthy foods can contribute to various poor health outcomes. In response to this deficiency, the City of Hartford, in partnership with farmers and community-based organizations, is working to

increase the number of farmers' market in the city. In 2011, there were 6 certified farmers' markets in the city accepting grant funds from the Women, Infants and Children federal program and its supplemental nutrition program, the Farmers' Market Nutrition Program. Furthermore, three of the markets were certified to accept Supplemental Nutrition Assistance Program benefits, which helped low-income people and families buy the food necessary for good health.

A report distributed by the University of Connecticut College of Agriculture and Natural Resources found that the presence of food retail resources were not significantly associated with community food security but income and lack of transportation that limit access to food are significantly associated. Despite high numbers of families enrolled in public food assistance, towns with greater rates of households headed by females or the elderly, or lack of education experience greater rates of food insecurity [8].

Foods that are highly processed contain both trans fats and refined sugars, and can lead to both diabetes and heart disease by increasing weight and cholesterol levels. The healthy food shopping choices available to Hartford residents are limited, and signal poor community health. More attention is needed for the overall food system components, including a greater focus on nutrition and cooking skills development.

VII. Health Indicators

As part of the assessment process, Key Informants were asked to rank the **five most significant health issues** in the City of Hartford. The respondents could choose from a list of 25 health issues as well as suggest their own that were not on the list. The five most identified – obesity, diabetes, mental illness, heart disease, and asthma – consisted of four health issues from the list and one write–in response.Mortality statistics are also noted in this section and infectious disease was included due in part to the unique age distribution of Hartford.

This section will also highlight how Hartford rates low in community health when compared to other Connecticut municipalities. As a result of its relatively low standing, this assessment focuses on a Hartford neighborhood comparative using city–specific indexing from the HEI in order to gain a richer understanding of city health concerns. The health outcomes included here are Life Expectancy, Mortality, Infant Mortality, Infectious Diseases, Respiratory Illness, Obesity/Heart Disease, Diabetes, and Mental Health.

Life Expectancy

Percent of deaths for the City of Hartford due to any of the top 10 causes of death in the U.S. are overall smaller when compared to the state and nation. The strongest positive determinant correlations with life expectancy are education, economic security, and civic involvement; with Hartford rating very low in each (HEI index of 2, 2, and 1, respectively).

Table 8. **Social Determinants of Health Related to *Life Expectancy***

	INDEX SCORE	CORRELATION COEFFICIENT
Education	2	0.64
Economic Security	2	0.61
Civic Involvement	1	0.50
Community Safety	1	0.41
Employment	3	0.35
Environmental Quality	4	0.34
Housing	3	0.31

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Table 9. **Top 10 Leading Causes of Death for Hartford, Connecticut and the U.S. (ranked from most to least common for Hartford; 2005-2007)**

	CITY OF HARTFORD	CONNECTICUT	U. S.
Heart Disease	**24.2%**	25.6%	25.4%
Malignant Neoplasms (Cancer)	**18.2%**	23.8%	23.1%
Accidents (Unintentional Injuries)	**5.5%**	4.2%	4.8%
Stroke (Cerebrovascular Disease)	**4.8%**	5.2%	5.5%
Chronic Lower Respiratory Diseases	**3.7%**	4.9%	5.3%
Diabetes	**3.4%**	2.6%	3.1%
Septicemia	**2.6%**	2.1%	1.4%
Influenza/Pneumonia	**2.4%**	2.9%	2.2%
Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Disease)	**2.3%**	1.9%	1.9%
Alzheimer's Disease	**1.2%**	2.6%	2.9%

However, the age-adjusted mortality rate (AAMR; defined as a death rate that controls for the effects of differences in population age distributions.) for all causes of death for the city is notably larger than that of the state and nation (876 compared to 692 and 778, respectively). With a younger population, this dramatic difference in the age-adjusted rate suggests that the mortality rate for older populations in Hartford is very high even though the elderly population itself may not be very large. Therefore, deaths due to heart disease and cancer low compared to the state and the U. S.

The Years of Potential Life Lost (YPLL; defined as an estimate of the average years a person would have lived if he or she had not died prematurely.) for Hartford was 10,647 per 100,000 for 2005-2007 for all causes of death. HEI scores Hartford 2 for YPLL. This measure correlated inversely with obtaining a bachelor's degree, and having a higher median household income and median value for owner occupied housing. It had a reverse effect for adults with less than a 9th grade education, so the lower level of education, the greater the years of potential life lost.

Infant/neonatal mortality is a major concern for Hartford; the mortality rates in Hartford for infants and neonates are markedly greater than those across Connecticut and the United States. Upon further examination, there is a pronounced disparity among infant deaths for infants of different races and ethnicities in Hartford; from 2001 through 2008, the mortality rate for Black infants was consistently higher than either the white or Hispanic infant mortality rate.

Figure 9. **Infant and Neonatal Mortality Rates* for Hartford, Connecticut, and the U.S. (2006)**

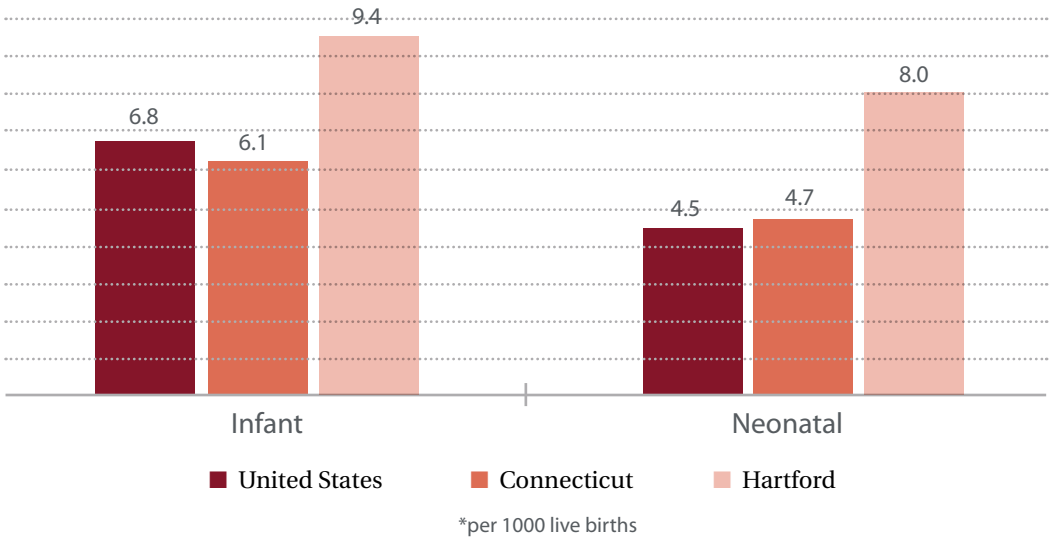
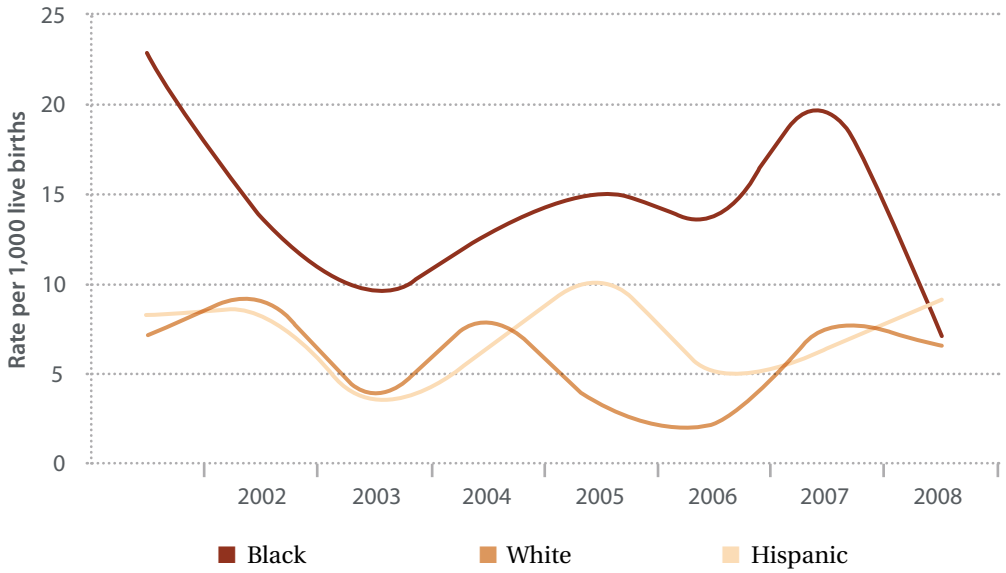
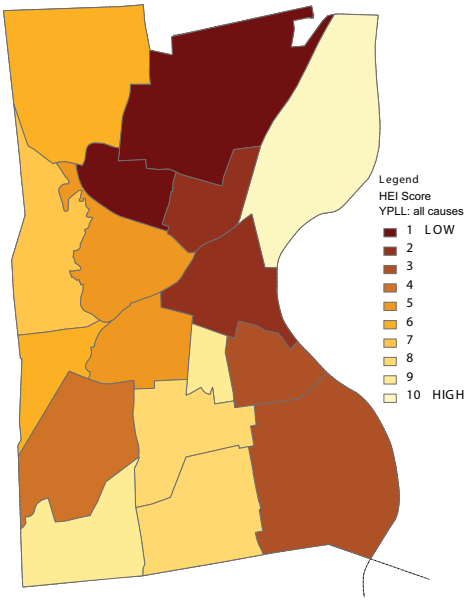


Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**



These adverse infant health outcomes greatly contribute to a lower than average life expectancy in Hartford. The following map highlights how its neighborhoods compare to each other with regard to the YPLL measure; the darker colors indicate a lower rating (greater number of years) for potential life lost. Six out of 15 neighborhoods (excluding the North and South Meadows neighborhoods) rated low on the YPLL. Per the HEI, the Northeast and Upper Albany neighborhoods were the lowest rated of all Hartford neighborhoods.

Map 3. **HEI Years of Potential Life Loss (YPLL) Score: All Causes by Neighborhood**



Infectious Diseases

In the state of Connecticut, there is a strong correlation of infectious disease with multiple social determinants, as demonstrated in Table 10.

Table 10. **Social Determinants of Health Related to *Infectious Disease***

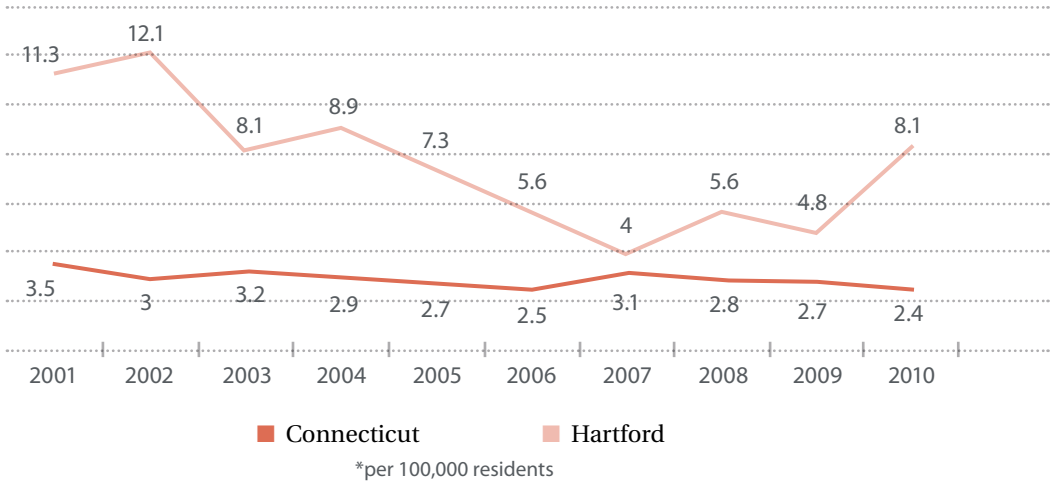
	INDEX SCORE	CORRELATION COEFFICIENT
Community Safety	1	0.67
Education	2	0.59
Environmental Quality	4	0.59
Civic Involvement	1	0.59
Economic Security	2	0.58
Housing	3	0.55
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

There is particular concern when examining **HIV** trends in the city. From 2002 through 2009 per the Connecticut Department of Public Health HIV Surveillance Program, the number of HIV infection cases declined for the city; however, there has been a 221% increase of new HIV infections among self-reporting men who have sex with men over the same time period, as well as a 123% increase in new infections amongst Hartford's Black residents.

There is an established correlation between HIV rates and rates of tuberculosis infection [9]; however, that does not seem to be the case in Hartford. Data from the Connecticut Department of Public Health's Tuberculosis Control Program shows that while tuberculosis rates in Connecticut are in decline, tuberculosis rates in Hartford are increasing.

Figure 11. **Tuberculosis Prevalence* in Hartford and Connecticut (2004-2010)**



The Connecticut Department of Public Health's STD Control Program provides information on infections more commonly associated with reproductive health. From 2007-2010, a total of 7768 cases of **chlamydia** were reported in Hartford (rate of 157 per 10,000 residents), which is almost 1.5 times higher than the next highest rate of chlamydia infection in the state. Among Blacks and Latinos, the rates were 12.1 and 5.3 times higher than those for whites, respectively. Of all the diagnoses reported during this period, approximately 70% of the cases were among 15 to 24-year olds; Black and Latino female adolescents and young adults accounted for about 36% and 20%, respectively, of all reported chlamydia cases during this same period.

Gonorrhea is the second most commonly reported STI in Hartford after chlamydia. Between 2007 and 2010, approximately 20% of the total reported cases of gonorrhea in the state occurred in Hartford (a rate of 40.5 per 10,000 residents). The rate of infection of women when compared to men was 1.5 times higher (119 versus 78 per 10,000 residents, respectively). Blacks and Latinos also had a disproportionate rate of infection when compared to whites (15.3 and 4.1 times greater, respectively); infection rates were also the highest for 15- to 24-year olds.

Since 2008 the prevalence of **syphilis** in Hartford has increased from 4.1 to 10.5 cases per 100,000 residents; and approximately 94% of all reported cases were male. A racial and ethnic disproportion is also reflected, as African American and Latino male rates were 9.2 and 4.3 times higher than white males, respectively.

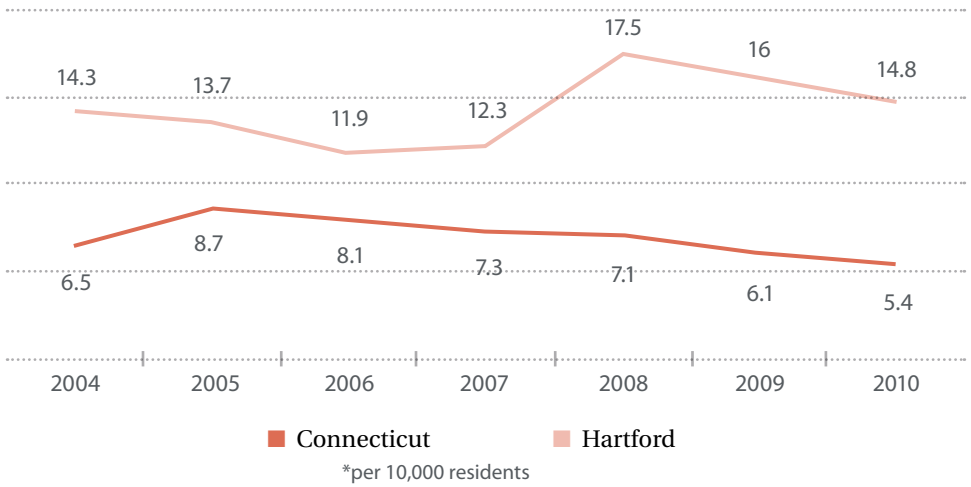
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

	PERCENT INFECTED
15-24 years old	34%
25-34 years old	10%
35-44 years old	41%

During this same time period, syphilis prevalence among males 25-34 year old increased 81% to 32 cases per 100,000; and among males 35-44 years old it increased 51% to 79 cases per 100,000.

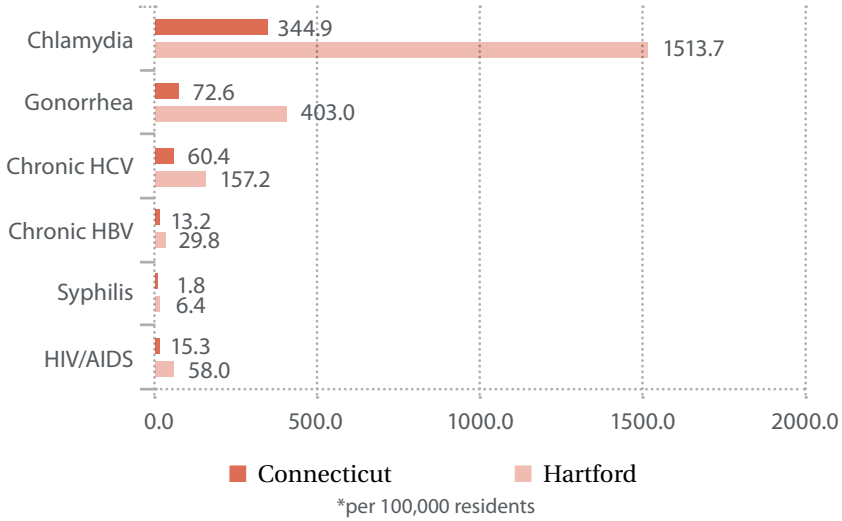
The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



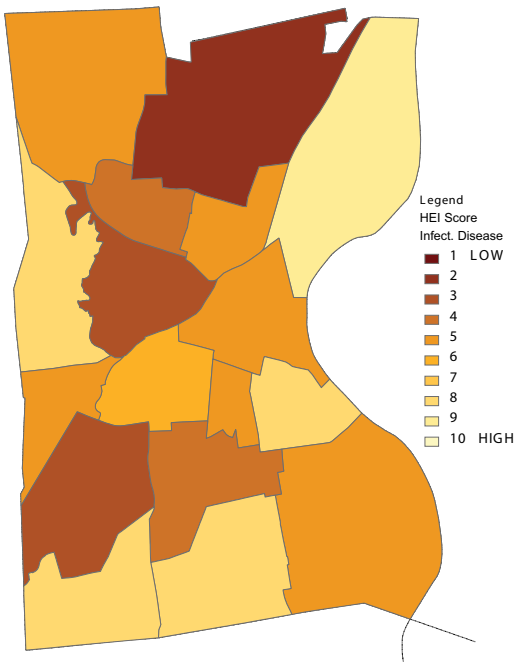
With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

Figure 13. **Infectious/Communicable Diseases Prevalence* in Hartford and Connecticut (2009)**



Using data from Connecticut's Department of Public Health, a comparison of how Hartford's neighborhoods compare to each other with regard to infectious diseases is demonstrated in the following map using the same HEI rating system; the Northeast rated lowest out of 17 total neighborhoods.

Map 4. **HEI Infectious Disease Score by Neighborhood**



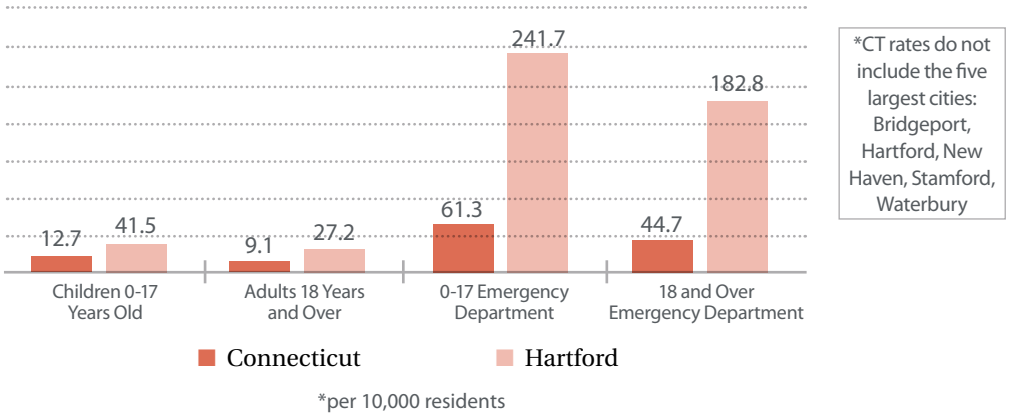
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

The Department of Health and Human Services and the Consortium can identify the prevalence of infectious diseases and provide resources to those who are in most need. The Department's division of Disease Prevention and Health Promotion has both an STD and TB clinic, as well as an HIV program, all geared to curtail infection rates and keep Hartford residents informed and educated. The federal government has passed legislation that provides for individuals who live with HIV/AIDS affordable, high-quality HIV care and related services. For those who are already established Ryan White consumers, there is a network of agencies and area providers that are connected to the city and in position to provide needed services and resources.

Respiratory Illness

Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

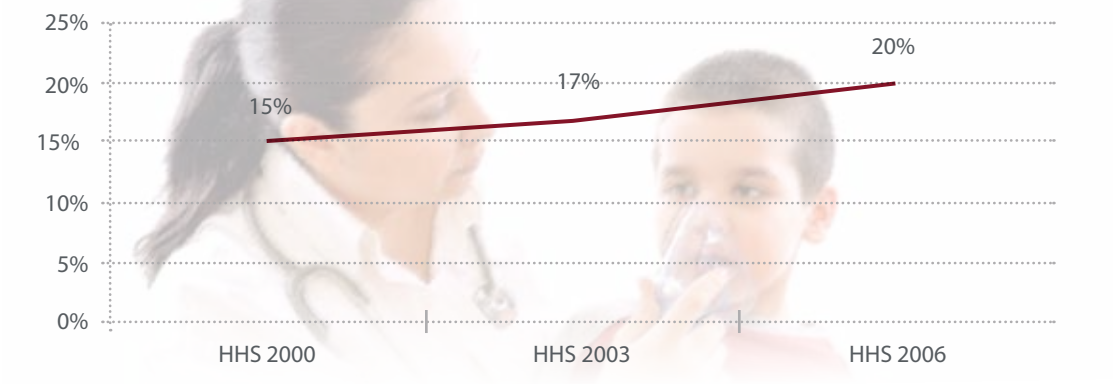
Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**



*per 10,000 residents

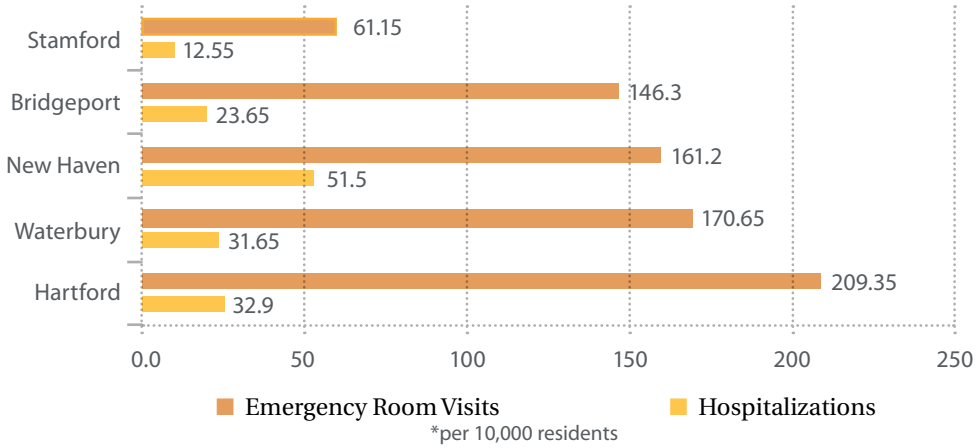
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

Figure 15. **Percent of Self-Reported Asthma from Hartford Health Survey (2006)**



Regardless of how residents self-report, Hartford has the highest rate of emergency room usage (209 ER visits for every 10,000) and the second highest rate of hospitalization for asthma as the primary cause of diagnosis (33 admissions per 10,000) when compared to other major Connecticut cities.

Figure 16. **Asthma Hospitalizations and Emergency Room Visit Rates* for All Residents by Connecticut City (2001-2007)**



Similar to asthma hospitalization rates, mortality rates are also an area of concern when compared to the rest of the state. The asthma-related mortality rate for men in Hartford is 22.4 per 10,000 men compared to 7.9 for the rest of Connecticut. Similarly, the mortality rate for women in Hartford is 42.5 compared to Connecticut's rate of 16.5.

In general, respiratory illness in Hartford has some moderate correlations, as noted in the following table, but the HEI indexed score is very low for each of the social determinants correlated to respiratory illness.

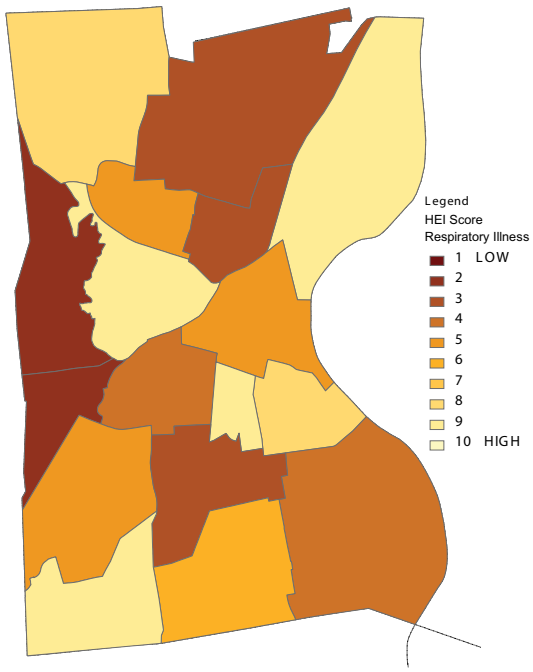
Table 12. **Social Determinants of Health Related to *Respiratory Illness***

	INDEX SCORE	CORRELATION COEFFICIENT
Economic Security	2	0.45
Education	2	0.41
Civic Involvement	1	0.31
Housing	3	0.29
Employment	3	0.28
Community Safety	1	0.26
Environmental Quality	4	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Using Connecticut Department of Health Office of Vital Records data, the HEI scores Hartford an overall indexed score of 4 when compared to other Connecticut towns and cities. The following map gives an indication of where the lowest scores lie when comparing among Hartford's neighborhood; the West End and Parkville neighborhoods ranked the lowest among Hartford neighborhoods with regard to respiratory health.

Map 5. **HEI Respiratory Illness Score by Neighborhood**



To help address these issues, the Asthma Call to Action Taskforce, a coalition of representatives from Hartford's Department of Health and Human Services, public schools, area hospitals, community organizations, and other agencies that are concerned about asthma in Hartford, seek to increase awareness about asthma to its residents, improve asthma care, establish a network of individuals and organizations to provide education and resources, and define asthma rate improvement strategies.

Obesity and Cardiovascular Disease

The percentages of obese Connecticut adults 20 years and older are notably higher for the Black and Hispanic populations (39.8% and 29%, respectively) than the state's white population (20.6%) [10]. Obesity is most commonly measured as a percentage of body fat based on height and weight. The following table shows the percent of healthy, overweight, and obese adults in the UnitedStates for all income levels as determined by the National Health and Nutrition Examination Survey. These weight category trends are similar when looking solely at people who are classified as "poor" (those who lived below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22, 314 for a family of four) by the US government. With a high rate of unemployment and a low HEI ranking for economic security, it can be assumed that obesity trends in Hartford are similar and that there is an increased relative risk for hypertension and adverse cardiovascular outcomes [11]."

Table 13. **United States Weight Categories**

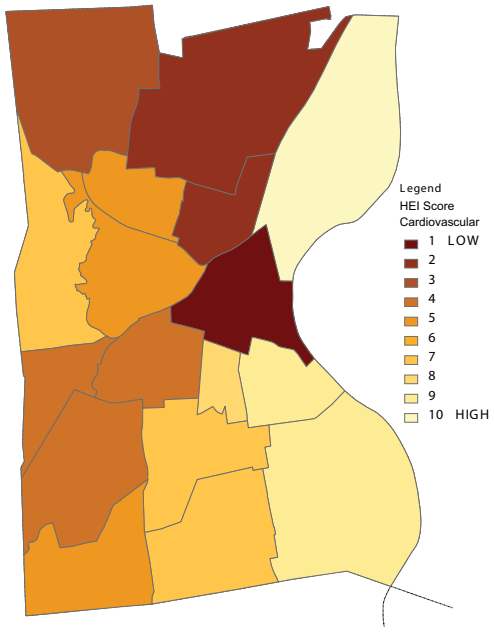
	HEALTHY WEIGHT	OVERWEIGHT	OBESE
1988-1994	41.9%	33.0%	22.7%
2001-2004	32.4%	34.7%	31.2%
2005-2008	30.9%	33.5%	33.9%

Similar rates emerge when looking at people who are classified as "poor" by the US government (those who live below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22,314 for a family of 4). With high rates of unemployment and a low HEI rating for economic security in Hartford, this trend is most likely mirrored in the city.

Downtown, the neighborhood with the lowest residential density, has the highest economic security and education scores, as well as the largest proportion of white residents. Despite such a low percentage of Hartford residents living Downtown, the fact that this population enjoys greater employment as well as health care coverage contributes to an increase in cardiovascular diagnoses and ultimately prevents undesirable health outcomes. For the remainder of Hartford's residents, cardiovascular health indicators remain elusive.

Obesity has been linked to both cardiovascular health and diabetes [12], and heart disease was the leading cause of death for Hartford from 2005 to 2007. The Northeast and Frog Hollow neighborhoods rate the poorest for these two significant risk factors.

Map 6. **HEI Cardiovascular Disease Score by Neighborhood**



There are several strong and moderate correlations with cardiovascular health, the top being education and economic security; below is a table listing the top five.

Table 14. **Social Determinants of Health Related to *Cardiovascular Health***

	INDEX SCORE	R_S VALUE
Education	2	0.51
Economic Security	2	0.48
Civic Involvement	1	0.42
Environmental Quality	4	0.36
Community Safety	1	0.33
Housing	3	0.29
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Diabetes

The fact that diabetes often presents as a co-morbidity with other diseases, it is difficult to segregate the information for just diabetes. The following table shows the age-adjusted percentages for adults 20+ for selected ethnic groups throughout the state; the data are from the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS).

Table 15. **Connecticut Residents with Diabetes by Race**

YEAR	ALL ADULTS	NON-HISPANIC WHITE	NON-HISPANIC BLACK	MEXICAN-AMERICAN
2005	7.2%	6.6%	14.3%	15.1%
2006	6.9%	6.4%	15.0%	10.4%
2007	8.3%	7.1%	20.4%	13.5%
2008	7.2%	6.2%	16.1%	11.6%
2009	6.8%	6.4%	13.0%	9.7%
2010	7.6%	7.0%	13.9%	9.5%

The rates are alarmingly higher for non-Hispanic Blacks, and Hispanics; these trends are the same across all economic levels, and substantially higher for those who live below and near the poverty threshold. Since 2007, there has been a significant improvement in these high rates as both the Black and Hispanic populations in the state have experienced a drop in the rate of diabetes, but there is still a diabetes health disparity drawn along racial lines for the state.

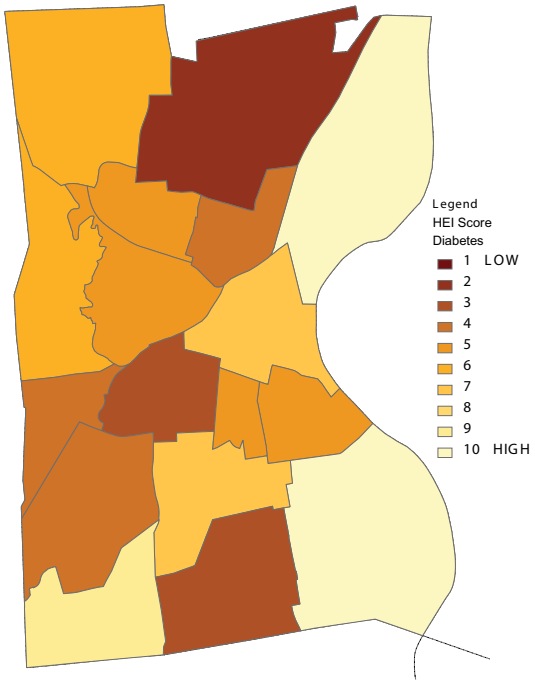
While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared to other racial/ethnic groups.

Figure 17. **Diabetes in Hartford for Adults**

Source: US Dept of Health and Human Services, The Office on Women's Health

The neighborhoods are compared to one another in the following map using the HEI indexing giving an indication where in Hartford diabetes is more of a health issue. The Northeast neighborhood ranks the lowest among Hartford neighborhoods.

Map 7. **HEI Diabetes Score by Neighborhood**

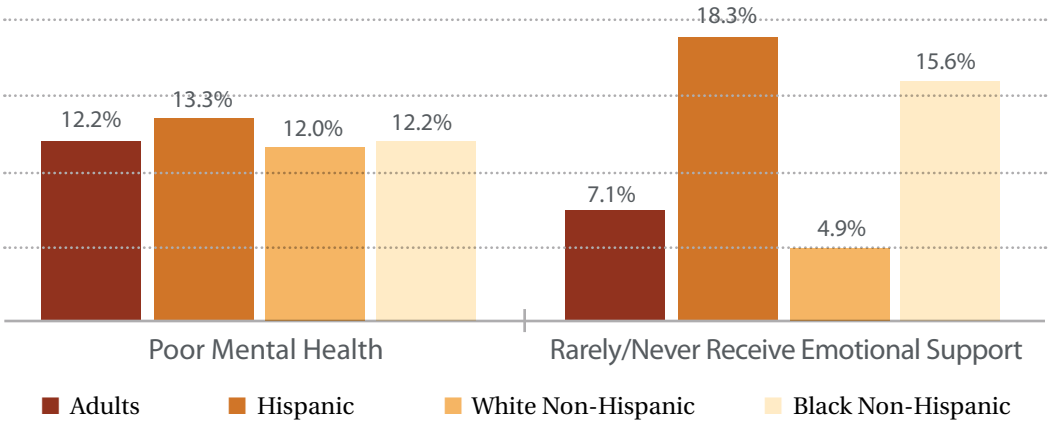


Behavioral Health

The HEI, using discharge data from the Connecticut Hospital Association and death information from the Connecticut Office of Vital Records, calculated an aggregate index score of 2 for mental health as a health indicator for Hartford. There are several significant correlations with mental health, including community safety (Rs=0.55), economic security (Rs=0.47), environmental quality (Rs=0.45), civic involvement (Rs=0.45), education (Rs=0.42), housing (Rs=0.37), and employment (Rs=0.23). With a low-indexed social determinant score, it can be inferred mental health issues are a significant health risk for the city. The BRFSS, a national system of state-based surveys, annually assessed how the residents fare with mental health issues. The results show that there is clearly a greater rate of Hispanics and Blacks self-reporting a lack of emotional support.

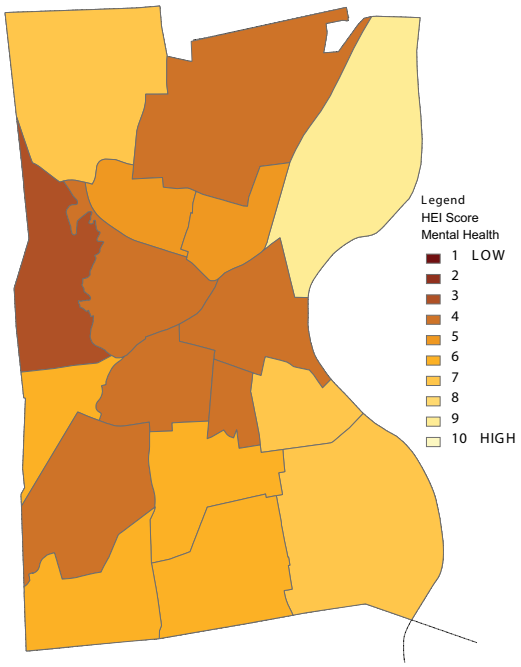
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for a more thorough investigation and coordinated approach. HHS is currently engaged in a collaborative partnership that includes planning for a Behavioral Health Needs Assessment in order to fully understand the nature of these services.

Figure 18. **Mental Health in Connecticut (Age Adjusted; 2007-2009)**



The neighborhood with the highest utilization of mental health services is the West End, which happens to be relatively affluent when compared to other city neighborhoods. The Consortium could hypothesize that individuals with greater access to specialized health care services would experience higher rates of diagnoses.

Map 8. **HEI Mental Health Score by Neighborhood**



VIII. Barriers to Services

The Urban Alliance survey asked respondents to consider barriers to health services and community resources. The most commonly reported barriers to service areas included not knowing about existing services (27%), lack of available services (22%), not able to pay (20%), and lack of transportation (20%).

Respondents were also asked to identify the most crucial **perceived service needs** for Hartford. Areas perceived as the most in need of additional services included homelessness/ housing (45%), education (41%), job training/employment assistance (39%), and basic needs/food assistance (36%). The top **actual service needs** were determined by respondents indicating that someone in their household would benefit from having additional service in this area. This resident survey found that the actual needs of the respondents were, for the most part, similar to the perceived needs of Hartford; three of the top five needs mentioned were common to both (see table below; ranked by most common responses and common responses bolded). The two areas - perceived and actual service needs - were explored separately to note differences, but with such high correlations in Connecticut between employment, education, and housing, as well as other factors, the overlap between the two areas is not as discordant as they appear to be.

Table 16. **Top 5 Needs for Hartford**

ACTUAL NEEDS	PERCEIVED NEEDS
Basic needs/food assistance services	Homelessness/housing
Financial support services	Education
Job training/employment assistance	Job training/employment assistance
Health and wellness	Basic needs/food assistance
Education	Youth development

The Key Informant interviews completed by the Consortium had similar findings. More than half of Key Informants chose either "Disagree" or "Strongly Disagree" with positive statements about access to care regarding dental services, medical specialists, a comprehensive model of primary care, providers who accept Medicaid, transportation, and health care delivery in Hartford.

Table 17. **Key Informant Perceptions of Health Care**

ACCESS/ BARRIERS TO CARE	"DISAGREE" OR "STRONGLY DISAGREE"
The majorities of Hartford residents are able to access and afford a dentist when needed.	88%
The majority of Hartford residents are able to access needed medical specialists.	83%
The majorities of Hartford residents are able to access and afford a primary care provider.	76%
Transportation to medical appointments is available to residents when needed.	73%
The healthcare delivery system in Hartford has a comprehensive approach to patient care.	71%
There is a sufficient number of providers accepting Medicaid or other forms of medical assistance.	70%
There is a sufficient number of bilingual healthcare providers in Hartford.	63%

IX. Conclusions

This Community Health Needs Assessment was assembled to give readers an overview of Hartford public health trends and to provide a platform to increase the communication across non-governmental as well as governmental agencies to improve the lives of city residents. The findings from this process demonstrate that Hartford residents include high concentrations of people at an increased risk for unhealthy living. After examining all the data sources used to create this report – the Key Informant Survey, the Hartford Survey Project, and the various secondary data that were analyzed – it is clear that marginalized and underserved populations are overrepresented in the city, and the need for establishing and expanding effective partnerships among city agencies is critical. Poverty, job opportunities, education, quality of housing, and neighborhood safety are quality of life measures that were most often mentioned by the Key Informants. All of these were highlighted in the data as areas where collaboration and renewed effort are necessary.

According to a recent model created by the University of Wisconsin's Population Health Institute, at least half of community wellness is driven by non-health factors such as education, housing, and pollution [13]. Connecticut, consistently one of the wealthiest states in the union, is also home to some of the nation's most significant gaps in leading societal determinants of health. For instance, when looking at poverty, Latinos are 4.7 times and Blacks are almost 3.6 times more likely to be living in poverty when compared with their white counterparts in Connecticut. These poverty rates among Black and Latino population reflect, in part, the terribly high unemployment rates in cities like Hartford, which have been crippled by unemployment rates at least 50% higher than that of the state. Coupled with things like a high percentage of single parent households with children present, these compromising circumstances make it difficult for Hartford residents and their families to achieve optimal health.

In addition to a high concentration of poverty, this assessment identifies other actionable non-medical factors that drive the state of health in Hartford. **Education**, for example, is a key indicator for economic security; low educational attainment coupled with limited employment opportunities adversely impact economic security of the city on a whole. Hartford's battle is a difficult one as one-third of Hartford adults do not have a high school diploma. And with one-fifth of the city's labor force unemployed and a high rate of service occupations for those who are employed, it is apparent that when people get off on the wrong foot, the path to occupations with increased responsibility and higher wages become all the more difficult.

The **housing** situation in Hartford makes it difficult to find up-to-date accomodations. The housing stock in Hartford is an aging one, where more than half of the housing available for both renters and buyers was built prior to 1950. And of all the housing occupied, less than a quarter of Hartford residents own their domicile; the majority has to choose from these old housing options.

Crime continues to be a problem in Hartford. With such a high number of youth living in the city, there is going to be an increased rate of violent and injury-related deaths. The city, having about 3.5% of the entire state's population, accounts for more than a third of all murders. In addition, there are some very specific health issues that should be highlighted:

- High age-adjusted mortality rates despite a population that is relatively young suggest that the senior population is dying at a high rate
- The diabetes rate, although well below Connecticut's rate, has climbed steadily in recent years
- As a percent of the total population in Hartford, residents who are obese are increasing while the percent of healthy weight adults declines
- The infant mortality rate in Hartford is much higher than Connecticut and the United States

Preventing problems before they arise is a particularly powerful tool in population health. These prevention efforts will result in a dramatic cost savings and reduction in social problems to our community. In 2009, the Mayor's office in collaboration with HHS designed and launched the Healthy Hartford wellness campaign, focused on many aspects of daily life in our urban environment. The goal of this campaign is to increase the availability of health related information and have community discussions designed to influence the choices that the Hartford citizenry at all ages makes regarding health behaviors like physical activity, proper eating, and other aspects of disease prevention. HHS launched a set of creative teams to design high-impact activities and approaches targeting all residents; the Healthy Hartford campaign was recently recognized by the U.S. Surgeon General and received the *Healthy Youth for a Healthy Future Champion Award* for its efforts to curb and prevent childhood overweight and obesity within our community. The Healthy Hartford campaign along with its many partners strives to reach the largest possible number of residents by designing interactive activities that target specific demographic groups throughout Hartford's 17 neighborhoods.

The Healthy Hartford campaign is a collaborative effort with area health providers and organizations to promote healthy choices and solutions to health problems by focusing efforts on a specific segment of the population or aspect of living in Hartford (i.e., youth, women, and men; Hartford workforce; and public policies that affect the health of the people). As an example, the recently formed Hartford Childhood Wellness Alliance draws on the combined leadership and expertise of community and professional groups across a spectrum of public health, medicine, academia, child care, and recreation to address the critical issue of childhood health and weight in Hartford. The Alliance provides a structure through which individuals and organizations can join together in the common interest of creating healthy environments for children and families, which in turn would be a cost saver to the city. Early in 2011, the Society of Actuaries calculated that the total economic cost of overweight and obesity in the United States is $270 billion per year as a result of an increased need for medical care, loss of worker productivity due to higher rates of death, loss of productivity due to disability of active workers, and loss of productivity due to total disability. Providing increased accurate chronic

disease self-management training to Hartford residents would have a positive impact on total cost to the city.

Collaboration holds the promise of allowing progress on issues where multiple parties are involved. Sustaining collaborations in Hartford is possible not only because of established partnerships but also because of efforts like such as this needs assessment, which will further strengthen existing relationships by highlighting where the major needs are. Any local health department is limited by available resources. Therefore, HHS' standard operating procedure is to constantly search for, and partner with, other organizations in order to better the lives of Hartford's citizenry.

The Public Health Advisory Council, a city charter-supported advisory panel, is an example of a sustained collaboration relative to residential health and chronic disease. Members of the panel include high-level representation from area hospitals, the Hispanic Health Council, the State of Connecticut Department of Mental Health and Addiction Services, the Connecticut Association of Directors of Health, and other community health organizations, and has regularly met for approximately the last 15 years. As experts on community health, the Public Health Advisory Council advices the city on many public health policies and initiatives.

In order to have improved collaborations throughout the city, there needs to be better data exchange among health organizations. Both health and societal data are not consistently collected, are difficult to compare longitudinally, and frequently may not tell the whole story. To improve the health of Hartford residents, HHS and its partners must have access to accurate local data. There are opportunities to make significant improvements in gathering and tracking such data on all of these issues, particularly on the issues of chronic diseases and risk factors that contribute to health disparities. It is imperative that those working in public health and providers of direct clinical services collaborate to develop a strategic plan for delivery of health care (including preventive care and mental health services) in a manner best suited to the community being served.

This report has presented a case that trends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services. Rather, these rates are a result of but also social, political, and environmental conditions. At the population level, major influences on health are structural. Throughout the development of this report, it has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services, a result of cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.

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XI. Appendix

A. Agencies that participated with the Key Informant Interviews:

Alcohol and Drug Recovery Centers, Inc.	Family Life Education
Asian Family Services (CRT)	Gay and Lesbian Health Collective
Blue Hills Civic Association	Greater Hartford Interdenominational Ministerial Alliance, Inc.
Boys and Girls Clubs	Greater Hartford Interfaith Coalition for Equity and justice
Cancer Program at Hartford Hospital	Hartford 2000
Capital Workforce Partners	Hartford Behavioral Health
Capitol Region Education Council	Hartford Community Schools
Casey Family Services	Hartford Foundation for Public Giving
Catholic Charities (Archdiocese of Hartford)	Hartford Hospital
Catholic Worker House	Hartford Office of Youth Services
Charter Oak Health Center	Hartford Public Schools
Child Health and Development Institute of Connecticut, Inc.	Hispanic Health Council
Children's Trust Fund	Immaculate Conception Shelter and Housing Corp.
Clay Arsenal Neighborhood Revitalization Zone	Injury Prevention Center at CCMC
Commission on Children	Institute for Community Research
Community Health Service	Institute for Hispanic Families s
Community Renewal Team, Inc. (CRT)	Interval House
Conference of Churches	Khmer Health Advocates
Connecticut Children's Medical Center (CCMC)	Latino Community Services
Connectikids	Malta House of Care, Inc.
CT African-American Affairs Commission	My Sister's Place
CT Association of Directors of Health (CADH)	Office for Young Children (COH)
CT Association of Human Services	Pediatric Clinic at Saint Francis Hospital
CT Coalition for Environmental Justice	Saint Francis Hospital
CT Department of Mental Health and Addiction Services	The Village for Families and Children
CT Department of Public Health	UConn Health Center
CT Department of Social Services	UConn School of Social Work
CT Voices for Children	United Way
Daughters of Eve	Urban League of Greater Hartford
Department of Community Outreach at Saint Francis Hospital Wellness	Easy Breathing at the Hartford Alliance for Childhood
Emergency Department at Hartford Hospital	Women's League Child Development Center

B. Key Informant Survey

City of Hartford 2010 Key Informant Survey

Good morning/afternoon, my name is _____ and I'm calling on behalf of the City of Hartford Department of Health and Human Services, CCMC, Saint Francis Hospital and Hartford Hospital. You should have received a letter from those institutions soliciting your participation in a brief survey that is part of a community needs assessment for the City of Hartford. You should have received a survey in advance to help us in this process; if that is not the case I could send one now and schedule for a latter time.

Do you have approximately 15-20 minutes to complete the survey with me? If not, I would be glad to schedule a time that is convenient with your schedule and call you back.

Please know that all of your responses will be held in strict confidence. No individual from the sponsoring organizations will have access to your individual survey. I'd like to emphasize that I am not an employee of the City of Hartford, but am affiliated with Holleran, a research firm located in Lancaster, Pennsylvania commissioned to conduct this research.

DEMOGRAPHICS

Area of Expertise:
Education Level:
Years providing services:

1. What is your vision of a healthy community?

2. What are the most significant barriers that residents of Hartford face when they attempt to access healthcare?

3. What specific populations in Hartford do you feel are not being adequately served by the healthcare system?

_____

_____

_____

4. In your opinion, what proportion of the population in Hartford views the hospital emergency room as their key source of primary care? _____%

Key Health Issues

1. In your opinion what are the five most significant health issues (most severe or most serious) you perceive in your community. The first one being the least important and the last one being the most important.

Caller: Read the list only if respondent needs prompting.

☐ Diabetes	☐ Substance Abuse
☐ Cancer	☐ Mental Illness
☐ Heart Disease	☐ Domestic/Family Violence
☐ Stroke	☐ Abuse of Children
☐ Obesity	☐ Sexually Transmitted Diseases – does not include HIV/AIDS
☐ Daily Life Stressors	☐ HIV/AIDS
☐ Reproductive Health	☐ Violence

Other _____

2. In your opinion what would be the best way to promote health prevention and wellness?

3. Regarding health and well-being, what needs of Hartford residents are currently begin met the best?

4. Regarding health and well-being, what would you say are the greatest unmet needs among residents of Hartford?

5 If you had to identify two key improvements that you feel are needed to provide better healthcare for area residents, what would they be?

a. _____
b. _____

Comments regarding Key Health Issues:

_____
_____
_____
_____

Quality of Life

1. On a scale of 1 (very poor) through 5 (excellent), please rate each of the following within the community.

1 = very poor; 2 = poor; 3 = average; 4 = good; and 5 = excellent.

NEIGHBORHOOD/ENVIRONMENT	Very poor « » Excellent
a. Availability of recreational activities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. Neighborhood safety	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. Clean, litter-free neighborhoods	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. Water or air pollution	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Quality of housing (affordable, in good condition)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. Road/traffic conditions	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
g. Schools/education	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
h. Job opportunities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
i. Availability of care for children	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
j. Poverty	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Quality of Life or any example that illustrates your answers:

2. What specific suggestions do you have for area hospitals and public health agencies to improve the quality of life in the community?

Quality of Care

1. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements.

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

HEALTHCARE	Strongly disagree « » Strongly agree
a. There are a sufficient number of bilingual providers in Hartford.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in the area are able to access a primary care provider.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. The majority of residents in the area are able to access a medical specialist.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The majority of residents in the area are able to access a dentist when needed.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Transportation for medical appointments is available to the majority of residents.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Healthcare or any example that illustrates your answers:

SOCIAL SERVICES	Strongly disagree « » Strongly agree
a. The majority of the residents in Hartford would know where to go if they needed mental health/ behavioral health treatment.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in Hartford would know where to go if they needed help with a substance abuse problem.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. There are a sufficient number of behavioral health providers in the area.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The healthcare delivery system in Hartford has a holistic approach to patient care?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Social Services or any example that illustrates your answers:

That concludes the survey. Thank you very much for your time today and we appreciate your feedback!

C. Hartford Resident Survey: English

URBAN ALLIANCE

HARTFORD RESIDENT SURVEY

URBANALLIANCE

You are being invited to complete this survey because you are a Hartford resident. We are interested in learning about services that would be helpful to you and your family as well as barriers to receiving these services. It is our hope that the results of this survey will enhance and increase services offered in the city of Hartford.

QUESTIONS ABOUT YOU

This survey begins with questions about you and your family. These help us to describe who completed the survey.

1. Do you live in the city of Hartford?
☐ Yes ☐ No
*Please provide your Zip Code:*_____

2. What is your ethnicity?
☐ Latino ☐ West Indian ☐ Multi-ethnic
☐ White ☐ African ☐ Other
☐ Asian American *Specify:*_____

3. What is your gender? ☐ Female ☐ Male

4. Do you attend a church?
☐ Yes *If yes, please specify which church:*
☐ No _____

5. How many adults live in your household? _____

6. How many children live in your household?_____

7. Check the box that best describes your age:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

QUESTIONS ABOUT SERVICES IN HARTFORD

*In the **first column (questions a & b),** indicate if you or someone in your household (someone who lives with you) would benefit from additional services in each area and barriers to receiving each type of service.*

*In the **second column (question c),** rank (1 through 3) the three areas most in need of additional services in the city of Hartford. Place the ranking in the box corresponding to each service area (1 indicates the area most in need of additional services). Complete this column after you have completed the first column (questions a & b) for each type of service.*

1. SUBSTANCE ABUSE RECOVERY *(e.g. treatment, prevention)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access substance abuse recovery services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

2. BASIC NEEDS/FOOD ASSISTANCE *(e.g. food pantry, meals, clothing, utility assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access basic needs/food services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

3. HOMELESSNESS/HOUSING *(e.g. emergency shelter, affordable housing)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access housing services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

4. COUNSELING/EMOTIONAL SUPPORT *(e.g. counseling, support group, stress management)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access counseling/emotional support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

5. YOUTH DEVELOPMENT *(e.g. leadership training, mentoring, after-school programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access youth development services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

6. HEALTH AND WELLNESS *(e.g. health care, screenings)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access health and wellness services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

7. EDUCATION *(e.g. tutoring, GED classes, ESL, literacy)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access education services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

8. FINANCIAL SUPPORT SERVICES *(e.g. personal finance planning, financial literacy, tax preparation)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access financial support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

9. ELDERLY SERVICES *(e.g. convalescent home, meals, senior center/programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access services for seniors? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

10. PRISONER /RE-ENTRY SERVICES *(e.g. visitation, re-entry assistance, support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access prisoner/re-entry services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

11. JOB TRAINING/EMPLOYMENT ASSISTANCE *(e.g. skill development, resume assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access job training/employment services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

12. PREGNANCY/PARENTING SUPPORT *(e.g. parenting/prenatal education and support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access pregnancy/parenting support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

D. Hartford Resident Survey: Spanish

ALIANZA URBANA
ENCUESTA SOBRE RESIDENTE HARTFORD

Usted está invitado a terminar esta encuesta porque usted es un residente de Hartford. Estamos interesados en aprender sobre los servicios que le serían provechosos a usted y su familia así como barreras para recibir estos servicios. Nuestra meta es mejorar y aumentar el alcance de los servicios ofrecidos en la ciudad de Hartford.

PREGUNTAS DE USTED

Esta encuesta comienza con preguntas sobre usted y su familia y nos ayudan a describir quién terminó la encuesta.

1. ¿Usted vive en la ciudad de Hartford?
☐ Sí ☐ No
*Proporcione por favor su Código postal:*_____

2. ¿Cuál es su pertenencia étnica?
☐ Latino ☐ Oeste Indio ☐ Multi-étnico
☐ Blanco ☐ Africano ☐ Otro
☐ Asiático Americano *Especifique*:_____

3. ¿Género? ☐ Femenino ☐ Masculino

4. ¿Usted asiste a alguna iglesia?
☐ Sí *Especifique por favor qué iglesia:*
☐ No _____

5. ¿Cuántos adultos viven en su casa? _____

6. ¿Cuántos niños viven en su casa?_____

7. ¿Está entre las edades de?:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

PREGUNTAS SOBRE SERVICIOS EN HARTFORD

*En la **primera columna** (preguntas a y b), indique si usted o alguien en su hogar serían beneficiado por servicios adicionales en cada área y también indique las barreras para recibir cada tipo de servicio.*

*En la **segunda columna** (pregunta c), Marque (1 a 3) las tres áreas más necesitadas de servicios adicionales en la ciudad de Hartford. Marque la caja que corresponde a cada área de servicio (1 indica la área más en necesidad de servicios adicionales). Termina esta columna después de que usted haya terminado la primera columna (preguntas a y b) para cada servicio.*

1. RECUPERACIÓN DEL ABUSO DE LA SUSTANCIA *(e.g. tratamiento, prevención)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de recuperacion del abuso de la sustancia?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguística	☐ Sin seguro medico
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	☐ Otro:

c. Marque las tres areas más necesitando adicional servicios ☐

2. NECESIDADES BASICAS/ASISTENCIA DE ALIMENTOS *(e.g. despensa de alimento, ropa, ayuda para utilidades)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de necesidades basicas/asistencia de alimentos?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	_____

c. Marque las tres areas más necesitando adicional servicios ☐

3. PERSONAS SIN HOGAR/VIVIENDA *(e.g. abrigo de emergencia, cubierta comprable)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de personas sin hogar/vivienda?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	_____

c. Marque las tres areas más necesitando adicional servicios ☐

4. ASESORAMIENTO/APOYO EMOCIONAL *(e.g. asesoramiento, grupo de ayuda)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de asesoramiento/apoyo emocional?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Sin seguro medico
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	☐ Otro:

c. Marque las tres areas más necesitando adicional servicios ☐

5. DESARROLLO DE LA JUVENTUD *(e.g. programas después de la escuela)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de desarrollo de la juventud?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

6. SALUD Y BIENESTAR *(e.g. cuidado médico, examenes)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de salud?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos ☐ Otro:

c. Marque las tres areas más necesitando adicional serivicios ☐

7. EDUCACIÓN *(e.g. tutoria, GED, ESL)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

¿Qué factores hacen difícil de tener acceso a sevicios de educación?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

8. SERVICIOS DE APOYO FINANCIERO *(e.g. preparación de impuesto, planificación financiera)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

9. SERVICIOS ENUEJECIENTES *(e.g. clínica de reposo, comidas, centro mayor/programas)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de enuejecientes?

☐ **Nunca henecesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

10. SERVICIOS DE PRISIÓN Y DE REINTEGRARSE *(e.g. visitation, ayuda del reingreso)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de re-entry del preso?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

11. ENTRENAMIENTO/BUSQUEDA DE TRABAJO *(e.g. ayuda de resume)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de asistencia trabajo de formación?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

12. SERVICIOS DE EMBARAZO/ CRIANZA DE LOS HIJOS *(e.g. educación y apoyo)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios del embarazos o criannza de los hijos?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

E. Data Sources for HEI Social Determinants

Social Determinants

- Civic Involvement
- Community Safety
- Economic Security
- Education
- Employment
- Environmental Quality
- Housing

Health Outcomes

- Accidents/Violence
- Cancer
- Cardiovascular Disease
- Childhood Illness
- Diabetes
- Health Care Access
- Infectious Disease
- Life Expectancy
- Liver Disease
- Mental Health
- Perinatal Care
- Renal Disease
- Respiratory Illness

For additional information about the HEI social determinants and health outcomes, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

F. Data Sources for Health Equity Index

Connecticut Secretary of State Office Voter Registration Statistics

Connecticut Department of Public Safety Uniform Crime Reports

2008 Warren Group Residential Statistics Report

2006-07 Home Mortgage Disclosure Act, Aggregate Reports; 2006-07 FFIEC Census Reports 2006-07

Housingpolicy.org

2000 US Census

Connecticut Department of Health Vital Records

RealtyTrac website, September 2008

2008 Connecticut Department of Social Services Temporary Family Assistance Data

Connecticut Department of Education's CEDaR site

2006 US Annual Economic Census ZIP Code Business Patterns reports; 2000 US Census

Connecticut Housing Finance Authority; 2005 US Census Population Survey

1995-2006 U.S. Annual Economic Survey

2002 US Economic Census Zip Code Statistics

US Environmental Protection Agency Toxic Release Inventory Program

Connecticut Housing Finance Authority; 2005 US Census Population Survey

Connecticut Department of Health, Office of Vital Records Death Certificates; 2007 Nielsen Claritas Population Facts Demographic Report

Connecticut Department of Health Tumor Registry; 2007 Nielsen Claritas Pop-Facts Demographic Report

2005 Connecticut Hospital Association CHIME Hospital Discharge Data

Connecticut Department of Health, Lead Poisoning Prevention and Control Program

Connecticut Department of Health, Office of Vital Records Birth Certificates

Connecticut Department of Health, Sexually Transmitted Surveillance Program

For additional information about the HEI data sources, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

Design by www.influentiald.com | Alberto Bonello

CITY OF HARTFORD DEPARTMENT OF HEALTH AND HUMAN SERVICES
131 Coventry Street | Hartford, CT 06112 | T 860.757.4700

EXHIBIT 22

KPMG

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Financial Statements and
Consolidating Information

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Health System, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Health System, Inc. (the System), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Health System, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

February 6, 2015

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 26,866	29,939
Short-term investments	17	29
Current portion of assets whose use is limited	5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,978 in 2014 and $9,395 in 2013	30,238	30,768
Other current assets	7,123	4,834
Total current assets	70,192	73,609
Marketable securities	24,966	22,365
Assets whose use is limited:		
By donor and held in trust by others	15,696	15,258
For estimated self-insurance liability	41,038	31,394
By bond indenture	4,321	4,324
Other	6	6
Total assets whose use is limited	61,061	50,982
Less current portion of assets whose use is limited	5,948	8,039
Noncurrent assets whose use is limited	55,113	42,943
Property and equipment, net	63,374	64,952
Other assets:		
Investments in joint venture arrangements	10,024	10,697
Deferred financing costs, net	103	128
Other noncurrent assets	241	241
Total other assets	10,368	11,066
Total assets	$ 224,013	214,935
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term obligations	$ 2,509	2,490
Accounts payable	17,369	20,985
Salaries, wages, and payroll withholdings	5,643	4,734
Due to third-party payors, net	783	6,035
Accrued expenses and other current liabilities	14,308	16,486
Total current liabilities	40,612	50,730
Long-term liabilities:		
Long-term obligations, net of current portion	17,891	20,374
Estimated self-insurance liability	31,814	21,908
Pension and deferred compensation	72,182	58,823
Other long-term liabilities	9,523	10,172
Total long-term liabilities	131,410	111,277
Net assets:		
Unrestricted	32,525	34,102
Noncontrolling interest in subsidiaries	370	302
Total unrestricted	32,895	34,404
Temporarily restricted	2,415	2,269
Permanently restricted	16,681	16,255
Total net assets	51,991	52,928
Total liabilities and net assets	$ 224,013	214,935

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowance	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	10,774	7,864
Total revenues	278,861	263,885
Expenses:		
Salaries and wages	113,553	108,933
Employee benefits	28,631	31,305
Supplies and other expenses	115,557	103,308
Provision for uncollectible accounts, net of recoveries	7	8
Depreciation and amortization	10,529	10,052
Interest	1,438	1,598
Total expenses	269,715	255,204
Operating income	9,146	8,681
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,684	1,758
Excess of revenues over expenses from continuing operations	12,830	10,439
Excess of revenue over expenses	12,830	10,439
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(387)	(485)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
Increase in unrestricted net assets	$ (1,509)	31,719

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,830	10,439
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(387)	(485)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,509)	31,719
Temporarily restricted net assets:		
Net assets released from restriction	(121)	(265)
Restricted contributions	267	165
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(937)	32,391
Net assets – beginning of year	52,928	20,537
Net assets – end of year	$ 51,991	52,928

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (937)	32,391
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,529	10,052
Net loss on disposal of assets	46	230
Change in unrealized (gains) losses on investments	527	(401)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures and partnerships	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	530	3,317
Other current assets	(2,264)	5
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,671)	2,932
Estimated self-insurance liability	9,906	2,846
Pension, accrued compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,685	25,775
Cash flows from investing activities:		
Purchases of property and equipment	(7,211)	(16,884)
Distributions from joint ventures and partnerships	546	798
Investments in joint venture arrangements	316	(106)
Change in other assets whose use is limited	(6,258)	(2,284)
Change in assets held in trust by others	426	949
Net decrease in investments	(3,116)	(98)
Net cash used in investing activities	(15,297)	(17,625)
Cash flows from financing activities:		
Decrease (increase) in assets whose use is limited by bond indentures	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net increase (decrease) in cash and cash equivalents	(3,073)	6,250
Cash and cash equivalents – beginning of year	29,939	23,689
Cash and cash equivalents – end of year	$ 26,866	29,939
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,562
Assets acquired under capital lease	—	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Health System, Inc. (SMHS or the System) is a not-for-profit, nonstock Connecticut holding company. It is the sole member of Saint Mary's Hospital, Inc. (the Hospital) and Saint Mary's Hospital Foundation, Inc. (the Foundation).

The Hospital is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, Scovill, Partners, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The Foundation was organized to raise funds to support the Hospital.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone,

measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow us to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The System invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by the Hospital's wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess (deficiency) of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The System has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The System recorded $53,000 and $49,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which is included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the System which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and

gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments In Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the System has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the System, the accounts of the System are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the System.

(k) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the System's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses, and equity in earnings of joint ventures are considered in the performance measure.

(l) Income Taxes

The System, Hospital, and Foundation are tax-exempt organizations as described in Section 501(c)(3) of the Internal Revenue Code and are generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2014 or 2013.

(m) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(n) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(o) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(p) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services after allowance for the years ended September 30, 2014 and 2013, is as follows (in thousands):

	2014	2013
Gross revenue from patient services	$ 733,919	670,163
Contractual and other allowances	(454,430)	(401,170)
Charity care	(328)	(94)
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	$ 268,087	256,021

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

		Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$	271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$	257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 19,021	19,021	—	—	—	—
Corporate bonds	12,451	12,428	1,088	(19)	4,653	(163)
U.S. government and agency obligations	14,177	14,141	2,926	(16)	1,686	(34)
Mutual funds	28,344	23,521	605	(62)	—	—
Equities	1,145	1,173	608	(9)	—	—
	$ 75,138	70,284	5,227	(106)	6,339	(197)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,809	2,809	—	—	—	—
Corporate bonds	15,837	16,628	928	(54)	734	(53)
U.S. government and agency obligations	13,930	13,135	3,731	(42)	304	(5)
Mutual funds	29,961	23,519	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 67,170	60,143	5,365	(112)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 18,229	—	—	18,229
Domestic corporate bonds	—	10,469	—	10,469
U.S. government and agency obligations	—	12,501	—	12,501
Equity mutual funds	17,635	—	—	17,635
Fixed income mutual funds	277	—	—	277
Equity funds	331	—	—	331
Total	36,472	22,970	—	59,442
Assets held in trust by others: Perpetual trust	—	—	15,696	15,696
Total	$ 36,472	22,970	15,696	75,138

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,445	—	—	2,445
Domestic corporate bonds	—	13,477	—	13,477
U.S. government and agency obligations	—	11,679	—	11,679
Equity mutual funds	19,508	—	—	19,508
Fixed income mutual funds	315	—	—	315
Equity funds	4,488	—	—	4,488
Total	26,756	25,156	—	51,912
Assets held in trust by others: Perpetual trust	—	—	15,258	15,258
Total	$ 26,756	25,156	15,258	67,170

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the System's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

Perpetual Trust	2014	2013
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains and losses	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(Continued)

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,926	7,343
Buildings and building improvements (10–40 yrs)	69,714	69,638
Equipment (3–25 yrs)	122,712	114,008
Projects in process	394	1,357
	200,746	192,346
Less accumulated depreciation and amortization	(137,372)	(127,394)
Property and equipment, net	$ 63,374	64,952

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997, the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund for the Bonds issued through CHEFA, of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds issued through CHEFA, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,310 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 34,404	34,102	302
Excess of revenues over expenses	12,830	12,398	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(387)	(23)	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 32,895	32,525	370

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 2,685	2,333	352
Excess of revenues over expenses	10,439	10,084	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(485)	(80)	(405)
Change in unrealized gains (losses) on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 34,404	34,102	302

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The System's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the System has no funds designated by the Board of Directors as endowment.

The System has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The System classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the System in a manner consistent with the standard of prudence prescribed by the Act.

The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the System and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$ 457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$ 375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$ 375	16,255	16,630
Investment return:			
Investment income	110	913	1,023
Net appreciation (depreciation)	(23)	264	241
Total investment return	87	1,177	1,264
Appropriation of endowment assets for expenditure	(5)	(751)	(756)
Endowment net assets, September 30, 2014	$ 457	16,681	17,138

(Continued)

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	375	16,255	16,630

The System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the System's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The System targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The System follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the System expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability claims have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and subject to change. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premium held on deposit at end of year	$	15,115	10,544

(Continued)

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The net actuarial loss that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit costs and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

(Continued)

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

(Continued)

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2022		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,147,000 and $5,982,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried on the equity basis, and the carrying value is

approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 671	543
Net assets released from restriction	46	68
Contributions	561	658
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful Use	2,962	1,149
Other	1,971	1,009
Total	$ 10,774	7,864

(19) Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,785	39,406
Fundraising	693	591
	$ 269,715	255,204

(20) Subsequent Events

The System has evaluated events through February 6, 2015, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the System's consolidated financial statements except as disclosed below.

The Hospital entered into an agreement to purchase 30.3% interest from limited partners of Naugatuck Valley MRI Limited Partnership for $700,000 in December 2014. The entity will be consolidated as a subsidiary in the consolidated financial statements going forward.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Current assets:					
Cash and cash equivalents	$ 25,797	1,069	—	—	26,866
Short-term investments	17	—	—	—	17
Current portion of assets whose use is limited	5,948	—	—	—	5,948
Accounts receivable, net	30,196	42	—	—	30,238
Other current assets	6,612	15	520	(24)	7,123
Total current assets	68,570	1,126	520	(24)	70,192
Marketable securities	20,803	4,163	—	—	24,966
Assets whose use is limited:					
By donor and held in trust by others	15,696	—	—	—	15,696
For estimated self-insurance liability	41,038	—	—	—	41,038
By bond indenture	4,321	—	—	—	4,321
Net interest in Foundation	5,182	—	—	(5,182)	—
Other	6	—	—	—	6
Total assets whose use is limited	66,243	—	—	(5,182)	61,061
Less current portion of assets whose use is limited	5,948	—	—	—	5,948
Noncurrent assets whose use is limited	60,295	—	—	(5,182)	55,113
Property and equipment, net	62,371	4	999	—	63,374
Other assets:					
Investments in joint venture arrangements	10,024	—	—	—	10,024
Deferred financing costs, net	103	—	—	—	103
Other noncurrent assets	—	—	241	—	241
Total other assets	10,127	—	241	—	10,368
Total assets	$ 222,166	5,293	1,760	(5,206)	224,013

(Continued)

Exhibit 1

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation, Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Current liabilities:					
Current portion of long-term obligations	$ 2,509	—	—	—	2,509
Accounts payable	17,252	87	30	—	17,369
Salaries, wages, and payroll withholdings	5,643	—	—	—	5,643
Due to third-party payors, net	783	—	—	—	783
Accrued expenses and other current liabilities	14,308	24	—	(24)	14,308
Total current liabilities	40,495	111	30	(24)	40,612
Long-term liabilities:					
Long-term obligations, net of current portion	17,891	—	—	—	17,891
Estimated self-insurance liability	31,814	—	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	72,182
Other long-term liabilities	9,523	—	—	—	9,523
Total long-term liabilities	131,410	—	—	—	131,410
Net assets (deficit):					
Unrestricted	30,795	1,923	1,730	(1,923)	32,525
Noncontrolling interest in subsidiaries	370	—	—	—	370
Total unrestricted	31,165	1,923	1,730	(1,923)	32,895
Temporarily restricted	2,415	2,291	—	(2,291)	2,415
Permanently restricted	16,681	968	—	(968)	16,681
Total net assets	50,261	5,182	1,730	(5,182)	51,991
Total liabilities and net assets	$ 222,166	5,293	1,760	(5,206)	224,013

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation, Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Revenues:					
Revenue from patient services, net of contractual allowance	$ 279,161	—	—	—	279,161
Provision for uncollectible accounts, net of recoveries	(11,074)	—	—	—	(11,074)
Net revenue from patient services	268,087	—	—	—	268,087
Other operating revenues	9,776	998	156	(156)	10,774
Total revenues	277,863	998	156	(156)	278,861
Expenses:					
Salaries and wages	113,207	308	38	—	113,553
Employee benefits	28,620	—	11	—	28,631
Supplies and other expenses	115,262	377	74	(156)	115,557
Provision for uncollectible accounts	—	7	—	—	7
Depreciation and amortization	10,455	1	73	—	10,529
Interest	1,438	—	—	—	1,438
Total expenses	268,982	693	196	(156)	269,715
Operating income (loss)	8,881	305	(40)	—	9,146
Nonoperating gains (losses):					
Investment income, net	3,824	—	—	—	3,824
Equity in earnings of joint ventures	189	—	—	—	189
Change in net assets of Foundation	281	—	—	(281)	—
Net loss on disposal of assets	(46)	—	—	—	(46)
Other	(283)	—	—	—	(283)
Total nonoperating gains, net	3,965	—	—	(281)	3,684
Excess (deficiency) of revenues over (under) expenses	12,846	305	(40)	(281)	12,830
Net assets released from restriction for capital expenditures	(48)	(5)	—	5	(48)
Capital transactions with affiliates	(363)	—	—	(24)	(387)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	(138)	—	138	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	(13,377)
Increase (decrease) in unrestricted net assets	(1,469)	162	(40)	(162)	(1,509)

See accompanying independent auditors' report.

KPMG

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

December 22, 2014

SAINT MARY'S HOSPITAL, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 25,797	28,902
Short-term investments	17	29
Current portion of assets whose use is limited	5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013	30,196	30,730
Other current assets	6,612	4,357
Total current assets	68,570	72,057
Marketable securities	20,803	18,506
Assets whose use is limited:		
By donor and held in trust by others	15,696	15,258
For estimated self-insurance liability	41,038	31,394
By bond indenture	4,321	4,324
Net interest in Foundation	5,182	4,874
Other	6	6
Total assets whose use is limited	66,243	55,856
Less current portion of assets whose use is limited	5,948	8,039
Noncurrent assets whose use is limited	60,295	47,817
Property and equipment, net	62,371	63,874
Other assets:		
Investments in joint venture arrangements	10,024	10,697
Deferred financing costs, net	103	128
Total other assets	10,127	10,825
Total assets	$ 222,166	213,079
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term obligations	$ 2,509	2,490
Accounts payable	17,252	20,899
Salaries, wages, and payroll withholdings	5,643	4,734
Due to third-party payors, net	783	6,035
Accrued expenses and other current liabilities	14,308	16,486
Total current liabilities	40,495	50,644
Long-term liabilities:		
Long-term obligations, net of current portion	17,891	20,374
Estimated self-insurance liability	31,814	21,908
Pension and deferred compensation	72,182	58,823
Other long-term liabilities	9,523	10,172
Total long-term liabilities	131,410	111,277
Net assets:		
Unrestricted Hospital	30,795	32,332
Noncontrolling interest in subsidiaries	370	302
Total unrestricted	31,165	32,634
Temporarily restricted	2,415	2,269
Permanently restricted	16,681	16,255
Total net assets	50,261	51,158
Total liabilities and net assets	$ 222,166	213,079

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowances	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	9,776	6,871
Total revenues	277,863	262,892
Expenses:		
Salaries and wages	113,207	108,642
Employee benefits	28,620	31,294
Supplies and other expenses	115,262	103,072
Depreciation and amortization	10,455	9,977
Interest	1,438	1,594
Total expenses	268,982	254,579
Operating income	8,881	8,313
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Change in net assets of Foundation	281	437
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,965	2,195
Excess revenues over expenses	12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	$ (1,469)	31,754

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,469)	31,754
Temporarily restricted net assets:		
Change in net assets of Foundation	146	(100)
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(897)	32,426
Net assets – beginning of year	51,158	18,732
Net assets – end of year	$ 50,261	51,158

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (897)	32,426
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,480	10,003
Net loss on disposal of assets	46	230
Change in unrealized losses (gains) on investments	527	(401)
Change in net interest in Foundation	(308)	(379)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	534	3,287
Other current assets	(2,255)	125
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,702)	1,522
Estimated self-insurance liability	9,906	2,846
Pension, deferred compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,350	24,062
Cash flows from investing activities:		
Purchases of property and equipment	(7,212)	(15,479)
Distributions from joint ventures	546	420
Investments in joint venture arrangements	316	272
Change in other assets whose use is limited	(6,258)	106
Change in assets held in trust by others	426	949
Net decrease in investments	(2,812)	(2,052)
Net cash used in investing activities	(14,994)	(15,784)
Cash flows from financing activities:		
Change in assets whose use is limited by bond indenture	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net (decrease) increase in cash and cash equivalents	(3,105)	6,378
Cash and cash equivalents – beginning of year	28,902	22,524
Cash and cash equivalents – end of year	$ 25,797	28,902
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,558
Supplemental disclosure of noncash item:		
Assets acquired under capital lease	$ —	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments in Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Interest in Foundation

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

(k) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

(l) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

(m) Income Taxes

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

(n) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(o) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(p) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(q) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

		2014	2013
Gross revenue from patient services	$	733,919	670,163
Contractual and other allowances		(454,430)	(401,170)
Charity care		(328)	(94)
Provision for uncollectible accounts, net of recoveries		(11,074)	(12,878)
Net revenue from patient services	$	268,087	256,021

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$ 271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$ 257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 18,630	18,630	—	—	—	—
Corporate bonds	11,820	11,807	1,062	(18)	4,559	(162)
U.S. government and agency obligations	14,023	13,990	2,926	(16)	1,686	(34)
Mutual funds	25,357	21,016	608	(9)	—	—
Equities	1,145	1,173	605	(62)	—	—
	$ 70,975	66,616	5,201	(105)	6,245	(196)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,671	2,671	—	—	—	—
Corporate bonds	15,083	15,885	4,668	(274)	734	(53)
U.S. government and agency obligations	13,769	12,984	3,731	(42)	304	(5)
Mutual funds	27,155	21,326	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 63,311	56,918	9,105	(332)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 17,838	—	—	17,838
Domestic corporate bonds	—	9,838	—	9,838
U.S. government and agency obligations	—	12,347	—	12,347
Equity mutual funds	14,925	—	—	14,925
Equity funds	331	—	—	331
Total	33,094	22,185	—	55,279
Assets held in trust by others:				
Perpetual trust	—	—	15,696	15,696
Total	$ 33,094	22,185	15,696	70,975

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,307		—	2,307
Domestic corporate bonds	—	12,723	—	12,723
U.S. government and agency obligations	—	11,518	—	11,518
Equity mutual funds	17,017	—	—	17,017
Equity funds	4,488	—	—	4,488
Total	23,812	24,241	—	48,053
Assets held in trust by others:				
Perpetual trust	—	—	15,258	15,258
Total	$ 23,812	24,241	15,258	63,311

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

	2014	2013
Perpetual trust:		
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,911	7,328
Buildings and building improvements (10–40 yrs)	67,094	67,017
Equipment (3–25 yrs)	122,662	114,099
Projects in process	395	1,217
	198,062	189,661
Less accumulated depreciation and amortization	(135,691)	(125,787)
Property and equipment, net	$ 62,371	63,874

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 32,634	32,332	302
Excess (deficiency) of revenues over expenses	12,846	12,414	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(363)	1	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 31,165	30,795	370

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 880	528	352
Excess (deficiency) of revenues over expenses	10,508	10,153	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(519)	(114)	(405)
Change in unrealized gains on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 32,634	32,332	302

(Continued)

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by the Act.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$ 457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$ 375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$ 375	16,255	16,630
Investment return:			
Investment income	110	913	1,023
Net (depreciation) appreciation	(23)	264	241
Total investment return	87	1,177	1,264
Appropriation of endowment assets for expenditure	(5)	(751)	(756)
Endowment net assets, September 30, 2014	$ 457	16,681	17,138

(Continued)

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	$ 261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	$ 375	16,255	16,630

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premiums held on deposit at end of year	$	15,115	10,544

(Continued)

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Preferred equity securities	—	—	—	—
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

(Continued)

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2024		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 280	276
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful use	2,962	1,149
Other	1,971	1,009
Total	$ 9,776	6,871

(19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,745	39,372
	$ 268,982	254,579

(20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

(21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current assets:						
Cash and cash equivalents	$ 24,610	823	—	364	—	25,797
Short-term investments	17	—	—	—	—	17
Current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Accounts receivable, net	26,816	2,999	(68)	381	68	30,196
Other current assets	6,108	253	5,749	17	(5,515)	6,612
Total current assets	58,696	4,075	10,484	762	(5,447)	68,570
Marketable securities	20,803	—	—	—	—	20,803
Assets whose use is limited:						
By donor and held in trust by others	15,696	—	—	—	—	15,696
For estimated self-insurance liability	—	—	41,038	—	—	41,038
By bond indenture	4,321	—	—	—	—	4,321
Net interest in Foundation	5,182	—	—	—	—	5,182
Other	6	—	—	—	—	6
Total assets whose use is limited	25,205	—	41,038	—	—	66,243
Less current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Noncurrent assets whose use is limited	24,060	—	36,235	—	—	60,295
Property and equipment, net	59,768	1,417	—	1,186	—	62,371
Other assets:						
Investments in joint venture arrangements	23,723	—	—	—	(13,699)	10,024
Deferred financing costs, net	103	—	—	—	—	103
Total other assets	23,826	—	—	—	(13,699)	10,127
Total assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

(Continued)

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current liabilities:						
Current portion of long-term obligations	$ 2,101	—	—	408	—	2,509
Accounts payable	16,795	432	—	25	—	17,252
Salaries, wages, and payroll withholdings	3,974	1,370	—	299	—	5,643
Due to third-party payors, net	783	—	—	—	—	783
Accrued expenses and other current liabilities	13,994	504	5,038	219	(5,447)	14,308
Total current liabilities	37,647	2,306	5,038	951	(5,447)	40,495
Long-term liabilities:						
Long-term obligations, net of current portion	17,818	—	—	73	—	17,891
Estimated self-insurance liability	3,278	—	28,536	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	—	72,182
Other long-term liabilities	9,464	59	—	—	—	9,523
Total long-term liabilities	102,742	59	28,536	73	—	131,410
Net assets (deficit):						
Unrestricted	27,668	3,127	13,145	924	(14,069)	30,795
Noncontrolling interest in subsidiaries	—	—	—	—	370	370
Total unrestricted	27,668	3,127	13,145	924	(13,699)	31,165
Temporarily restricted	2,415	—	—	—	—	2,415
Permanently restricted	16,681	—	—	—	—	16,681
Total net assets	46,764	3,127	13,145	924	(13,699)	50,261
Total liabilities and net assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HOSPITAL, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Revenues:						
Revenue from patient services, net of contractual allowances	$ 248,807	24,157	—	6,197	—	279,161
Provision for uncollectible accounts	(10,078)	(996)	—	—	—	(11,074)
Net revenue from patient services	238,729	23,161	—	6,197	—	268,087
Other operating revenues	8,706	4,039	5,070	16	(8,055)	9,776
Total revenues	247,435	27,200	5,070	6,213	(8,055)	277,863
Expenses:						
Salaries and wages	85,350	26,689	—	1,168	—	113,207
Employee benefits	24,562	3,778	—	280	—	28,620
Supplies and other expenses	106,022	9,260	4,092	3,370	(7,482)	115,262
Depreciation and amortization	9,888	283	—	284	—	10,455
Interest	1,405	—	—	33	—	1,438
Total expenses	227,227	40,010	4,092	5,135	(7,482)	268,982
Operating income (loss)	20,208	(12,810)	978	1,078	(573)	8,881
Nonoperating gains (losses):						
Investment income, net	2,279	—	1,545	—	—	3,824
Equity in earnings of joint ventures	3,359	—	—	—	(3,170)	189
Change in net assets of Foundation	281	—	—	—	—	281
Net loss on disposal of assets	(46)	—	—	—	—	(46)
Other	(856)	—	—	—	573	(283)
Total nonoperating gains (losses), net	5,017	—	1,545	—	(2,597)	3,965
Excess (deficiency) of revenues over expenses	25,225	(12,810)	2,523	1,078	(3,170)	12,846
Net assets released from restriction	(48)	—	—	—	—	(48)
Capital transactions, net	(14,778)	14,778	—	(910)	547	(363)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	—	(486)	—	486	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	—	(13,377)
(Decrease) increase in unrestricted net assets	$ (3,505)	1,968	2,037	168	(2,137)	(1,469)

See accompanying independent auditors' report.

EXHIBIT 23

Internal Revenue Service

Date: JAN 15 2009

SAINT MARYS HOSPITAL INC
56 FRANKLIN ST
WATERBURY CT 06706-1253

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:
Michelle Jones
ID# 0203153
Toll Free Telephone Number:
877-829-5500
Federal Identification Number:
06-0646844
Group Exemption Number:
0928

Dear Sir or Madam:

This is in response to your request of November 14, 2008, regarding your tax-exempt status.

Our records indicate that you are recognized as exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. You are included in the group ruling issued to the United States Conference of Catholic Bishops, which is not a private foundation within the meaning of 509(a) of the Code because it is described in section 509(a)(1) and 170(b)(1)(A)(i).

The United States Conference of Catholic Bishops is listed in Publication 78. Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to them or for their use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Since you are included in a group ruling, there is no individual exemption letter. The group exemption letter applies to all of the subordinate organizations on whose behalf the United States Conference of Catholic Bishops has applied for recognition of exemption. If you want a copy of the group exemption letter, please contact your central organization.

If you are operating an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, you are required to file Form 5578, *Annual Certification of Racial Nondiscrimination for a Private School Exempt From Federal Income Tax.* Form 5578 is due annually by the 15th day of the 5th month following the end of the organization's accounting period.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

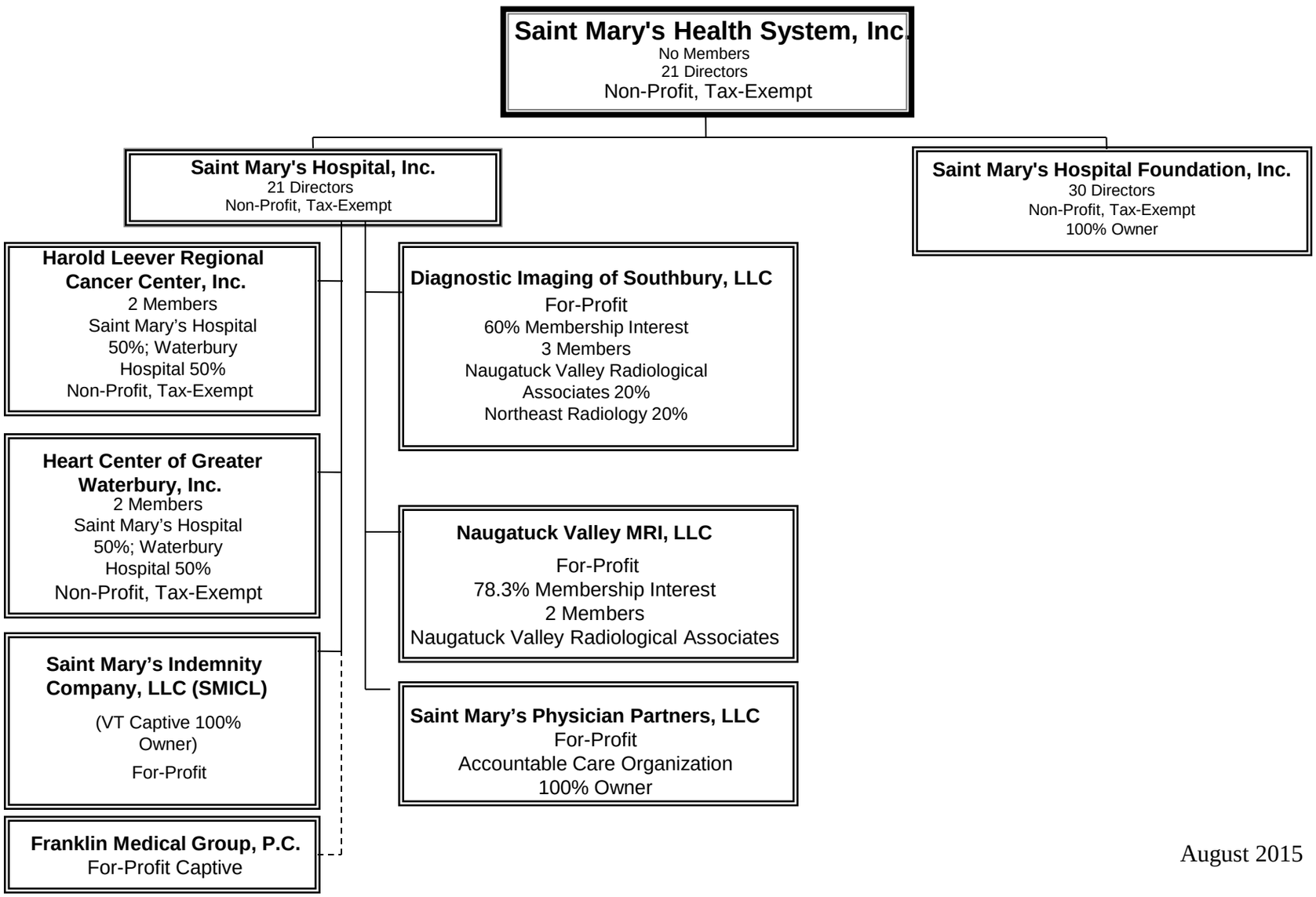
Sincerely,

Cindy Westcott

Cindy Westcott,
Manager, Exempt Organizations
Determinations

EXHIBIT S1

Corporate Structure



August 2015

EXHIBIT S2

Saint Mary's Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 1,800 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2013, Saint Mary's Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with The Greater Waterbury Health Improvement Partnership. The partnership consists of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Saint Mary's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs.

THE CHNA PROCESS

Saint Mary's Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Community Needs
6. Implementation Strategy

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Waterbury Department of Public Health, Connecticut Department of Health, and Centers for Disease Control and Prevention, among others. The report depicts the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System (BRFSS) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Saint Mary's Hospital in addressing the identified barriers.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA) and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

Saint Mary's Hospital developed an **Implementation Strategy** to outline what community health needs it plans to address, as well as specific goals and measures to evaluate community health improvement initiatives.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated by partners of the the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives of the session were:

- To review recently compiled community health data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

Prioritization Process

Holleran Consulting facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community. Through facilitated discussion, attendees developed the following "Master List" of potential priority areas.

Master list of community priorities (in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

Key Community Health Issues

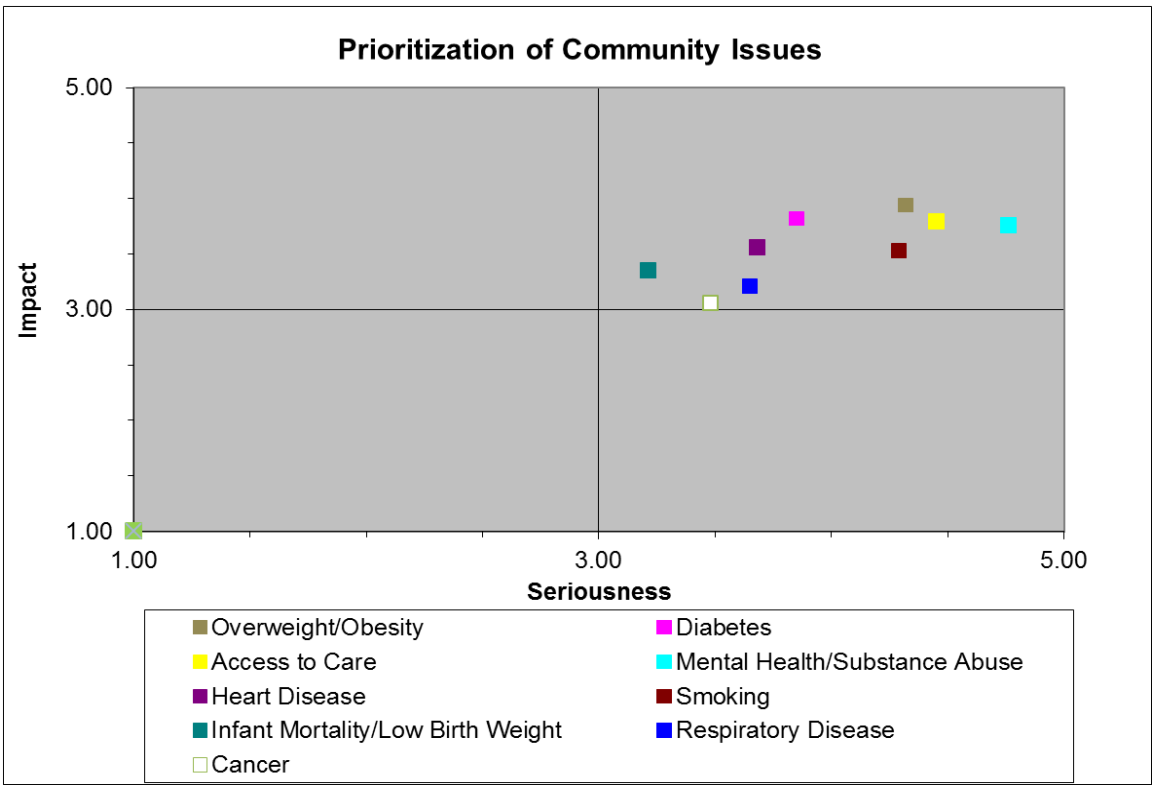
Once the Master List was compiled, participants were asked to rate each need based on two criteria. The two criteria included the "seriousness of the issue" and the "community's ability to impact the issue." Respondents were asked to rate each issue on a scale of 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact). The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee

received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.76), followed by Access to Care (4.45), and Overweight and Obesity (4.32). The ability to impact Overweight and Obesity was rated the highest (3.94), followed by Diabetes (3.82), and Access to Care (3.79).

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Chronic Disease (Obesity, Diabetes, Heart Disease and Asthma)
- Smoking

STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the four priority areas are listed below.

I. Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

Key Indicators:

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

Existing Programs

Hospital-Based Access to Care Programs

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2012, these advocates assisted 656 individuals in obtaining insurance coverage.

Grant-Funded

- Saint Mary's has received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs Medical Home. This Medical Home develops care plans and provides healthcare for children and youth with chronic physical and/or behavioral issues.
- Saint Mary's has grant funding from the Connecticut Department of Public Health for the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS), which was formerly known as the Breast and Cervical Grant. This program provides screening for breast and cervical cancer and if a cancer is diagnosed through the grant, funds are available for treatment. CHDIHS recently integrated a colorectal screening component.
- Saint Mary's Children's and Family Health Center, Dental Clinic and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have

Medicaid. Thousands of patients receive services through these clinics; these clinics have over 50,000 visits per year.

Initiatives

- Collaborate with the Connecticut Health Insurance Exchange to help residents gain access to health insurance.
- Evaluate opportunities to improve access to primary and urgent care.
- Enhance cost estimate and insurance verification programs so patients can better understand financial responsibilities in advance.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care) for uninsured/underinsured and low income patients and families.
- Develop nurse navigator programs where appropriate to improve access to primary care and behavioral health.

Existing Community Resources

Chase Family Resource Center
Community Health Centers, Inc.
Malta House of Care
New Opportunities, Inc.
StayWell Health Center, Inc.
Waterbury Health Access Program
Waterbury Department of Public Health

II. Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase number of points of access for referral to services

Key Indicators

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental / behavioral health.
- Length of stay in ED for mental / behavioral health patients.
- Number of ED referrals for mental / behavioral health care services.

Existing Programs

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 12, 611 patients were discharged from the unit. The average length of stay in the unit is 6.36 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,800 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2012, 11,163 ED patients had a primary diagnosis related to behavioral health. These patients represent 16% of total visits (70,067). The average length of stay for behavioral health patients in the ED was 38.4 hours or 1.6 days. Some of the ED behavioral health patients receive services in the seven-bed behavioral health holding unit.

Initiatives

- Evaluate options to enhance Behavioral Health unit in the Emergency Department to better meet patient needs.
- Analyze potential for development of a Community Crisis Center or Behavioral Health Walk In Center.
- Evaluate options to develop a Geriatric Emergency Department Program to reduce unnecessary ED utilization.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions.
- Evaluate Community Care Team program based at Middlesex Hospital and determine if a similar model could work in Waterbury.
- Evaluate potential for an ambulatory detoxification program.

Resources

Catholic Family Services
Community Health Centers, Inc.
Family Services of Greater Waterbury
Home to Home Foundation
Neighborhood Housing Services of Waterbury
StayWell Health Center, Inc.
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Youth Services
Wellmore Behavioral Health

III. Chronic Diseases (Obesity, Heart Disease, Diabetes, and Asthma)

Goal: Promote health and reduce chronic disease through healthy eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Reduce risk factors for chronic disease

Indicators:

- Number and percent of patients who are obese or overweight at the time of their visit.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children in the Early Obesity Prevention Program that demonstrate improved weight.
- Number of children who receive meals through the Health Nutrition Grant.
- Number of physicians participating in the Easy Breathing Program.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Number and percent of residents utilizing the farmer's market who report increased consumption of fruits and vegetables.
- Number of food prescriptions written.

Existing Programs

Obesity and Heart Disease

- Saint Mary's offers inpatient and outpatient nutritional counseling.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2012, 112 patients had obesity surgery.
- Saint Mary's works with community organizations on the Early Childhood Obesity Prevention Program. This program is funded by Saint Mary's Hospital, the Connecticut Community Foundation and the American Heart Association. The grant is in its first phase to collect local data on childhood obesity. The second phase will include developing interventions to reduce obesity.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a Mindful Meal Program that includes low calorie and low fat healthy food options.

Asthma and Diabetes

- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- The Connecticut Community Foundation and the American Hospital Association has awarded Saint Mary's a grant for diabetes education in the Naugatuck area. This is collaboration with the Heart Center of Greater Waterbury.

Initiatives

- Collaborate with Brass City Harvest to offer a farmer's market.
- Evaluate ways to continue to improve meal choices at the hospital.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Participate in the American Heart Association Mission Lifeline Program.
- Determine possibility of holding community education and screening events in collaboration with local providers.
- Provide nurse educator to patients with Congestive Heart Failure to coordinate post-acute care services and provide patient and family education.

Resources

- Brass City Harvest
- Bridge to Success Community Partnership
- Community Health Centers, Inc.
- End Hunger Connecticut
- Heart Center of Greater Waterbury
- New Opportunities, Inc.
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

IV. Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Key Indicators

- Number of people participating in smoking cessation programs and percent that successfully quit smoking.
- Number of patients who receive smoking cessation counseling.

Existing Programs

- The American Lung Association has awarded Saint Mary's tobacco cessation funds. Funds are currently available to cessation classes.
- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.

Initiatives

- Work with Harold Leever Regional Cancer Center to enhance smoking cessation program.
- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.

Resources

- Community Health Centers, Inc.
- Harold Leever Regional Cancer Center
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Saint Mary's Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Saint Mary's Hospital Board of Directors met on September 12, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants – June 18, 2013

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living

Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT S3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/14

NAME OF FACILITY SAINT MARY'S HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 56 FRANKLIN ST, WATERBURY, CT 06706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A000	INITIAL COMMENTS An authorized substantial allegation survey was concluded on October 29, 2014 in response to complaint #CT 17479 at: Saint Mary's Hospital 56 Franklin St. Waterbury, CT 06706 The following Conditions of Participation were reviewed as they pertain to the complaint: Physical Environment 482.41 Infection Control 482.42 Governing Body 482.12 QAPI 482.21 Pharmaceutical Services 482.25	A000		
A083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions for the contracted service.	A083		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) Date

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A083	This STANDARD is not met as evidenced by: Based on observation, a review of facility documentation, and staff interviews the facilities governing body failed to ensure the hospitals quality program assessed services provided by an outside environmental monitoring company to identify quality and performance issues. The finding includes: During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the	A083	Applies to tag A083 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board. Responsible Person: Director of Pharmacy	October 30, 2014 Indefinite

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A083	Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. Interview with the Vice President of Nursing on 10/29/14 at 1:30 PM identified the governing body was not made aware of the environmental testing that was conducted in the pharmacy to ensure monitoring, improvement activities, and sustainability of quality problems. The hospital bylaws dated 12/20/07 directed in part, the quality coordinating council would monitor the performance improvement activities carried out within the hospital. Further review of the bylaws identified the governing body would be responsible to review infection control as it is related to the development of a mechanism for monitoring and reporting environmental condition with infection potential.	A083		
A273	482.21(a), (b)(1), (b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve	A273		

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A273	Health outcomes (2) The hospital must measure, analyze, and track quality indicators and other aspects of performance that assess processes of care, hospital services and operations. (b) Program data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care and (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidence by: Based on a review of the hospital documentation and interview with hospital personnel, the facility failed to assess and/or analyze environmental testing conducted in the pharmacy and/or failed to incorporate the hospital's quality improvement program to ensure patient safety and quality of care. The finding includes: .	A273		

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A273	During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. The hospital's performance improvement management plan directed in part, a performance improvement plan specific to the department's scope of care and to ensure the deployment of strategies based on measurement and assessment of process and outcomes.	A273	Applies to tag A273 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board. Responsible Person: Director of Pharmacy	

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	The chief executive officer, senior leadership and the executive leadership team would be responsible for assuring the identified key projects are reflected, measured and evaluated in the performance improvement plan with outcomes documented.			
A724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on review of facility documentation, review of facility policy, review of manufacturer's recommendations, observations and interviews, the facility failed to ensure that pharmacy equipment inspections and/or cleaning maintenance was conducted/documented as per manufacturer's recommendation, and/or facility policy and/or state law. The finding includes: A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00 PM identified that the pharmacy had three glove compounding isolators. Isolator #3 had a maintenance sticker dated fir 9/2014 on the outer right side of the isolator. Review of isolator inspection documentation on 108/28/14 at 2:05PM indicated that all three isolators had HEPA	A724	Applies to tag A724 Pharmacy Department and Facilities have both created an automated alert 3 weeks prior to the required inspection of the isolators as a reminder for follow up to Facilities contracted service for cleaning. In addition to contracted cleaning, twice monthly terminal cleaning has been scheduled with sporacidal disinfectant for the IV rooms. Monitoring: Pharmacy Department will maintain an inspection log and this will be submitted to the Quality Department on an annual basis. Responsible Person: Director of Pharmacy	

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A724	Filters and air velocity testing, by Company #2 on 1/20/13 and 7/8/13, testing was not conducted for January 2014. A change in vendor on 9/24/14 identified that Company #3 only tested isolators #2 and #3, and that isolator #1 was not tested. Interview with the Director of Pharmacy on 10/28/14 at 2:05 PM noted that there was a glitch in the testing schedule, Company #2 did not test the equipment in January 2014 as per contract and Company #3 was only capable of testing the positive pressure isolators, Isolator #2 and #3. The facility submitted a corrective action plan on 10/28/14 that included testing of the negative pressure isolator, Isolator 31, scheduled for 10/29/14. The facility IV Infection Control policy directed that, barrier isolators are inspected and certified every six months.	A724	Applies to tag A749 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board.	
A749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying documentation, review of facility policy, and interviews the facility failed to ensure that the infection control department was informed of positive mold cultures in the medication compounding area. The finding includes: 1. A tour of the pharmacy department was conducted on 10/27/14 at 2:00PM with the Director of Pharmacy. Observation on 10/27/14 at 2:00PM identified a door at the back of the department lead to a room that contained, in part, three isolators for medication compounding. Review of facility	A749	Responsible Person: Director of Pharmacy	October 30, 2014 Indefinite

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A749	contracts and/or environmental monitoring reports on 10/27/14 indicated that Company #1 performed environmental culturing in the pharmacy department as per facility contract. The monitoring reports further noted that 1 to 3 mold spores were cultured on the surfaces and/or floor and/or in the air of the medication compounding room (not in the compounding isolators) in January, February, May, June, July, August, and September 2014. The monitoring reports further documented that the Director of Pharmacy did not take steps to remediate the presence of mold until June 2014 when cleaning processes were reviewed, and/or when dynamic testing was conducted in August 2014 and/or the institution of a "sticky mat" in September 2014. Review of Pharmacy and Therapeutics committee minutes from 1/2014 to 9/2014 lacked documentation of the mold spores and/or the steps taken by pharmacy to remediate the mold. Review of Infection Control (IC) meeting minutes from 1/2014 to 9/2014 lacked documentation of the pharmacy cultures and/or remediation. Interview with the Director of Pharmacy on 10/27/14 at 2:30PM identified that although the pharmacy mold levels were far below actionable levels, he consulted with the contracted microbiologist for ideas to eliminate/decrease the mold.	A749		

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A749	Review of IC meeting minutes and further interview with the Director of Pharmacy on 10/27/14noted that the IC team had never been made aware of an/or been involved in environmental culturing results/remediation's as the levels were non-actionable. Interview with the Infectious Disease Physician on 10/29/14 at 11:12Am indicated that, going forward, he/she would like to see a grid to reflect known unacceptable culture levels and the pharmacy culture results trends. The facility IC plan identified that the program was an institution-wide program whose main objectives are the prevention and control of infections. The IC plan included a major function to design and execute routine surveillance data collection and analysis activities and to develop review, and revise hospital-wide infection prevention policies and procedures. According to the USP 797, highly pathogenic microorganisms, to include mold, must be immediately remedied regardless of the colonizing forming unit count, with the assistance of a competent microbiologist, IC professional or industrial hygienist. 2. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items in the antechamber of Isolator #3, sprayed the antechamber with sterile 70% Isopropyl alcohol and after donning	A749		

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A749	the isolator's gloves/sleeves, moved the items form antechamber to the main chamber and began the medication compounding procedure. Following the procedure, Pharmacy Technician #1 moved the items to the antechamber, removed his/her gloved hands from the isolator's gloves/sleeves and removed all items from the antechamber. Pharmacy cleaning logs identified that Glove Box A and Glove Box B (Isolators #2 and #3) were cleaned on each shift. The cleaning logs laced evidence of any additional cleaning of Isolators #1 and/or cleaning of the negative pressure isolator (Isolator #1). In addition documentation could not be provided for required isolator glove changes. Interview with the Director of Pharmacy on 10/27/14 at 2:30 PM indicated that isolator glove are changed daily and on the morning shift and that this was not documented. He further noted that additional cleaning of isolators was performed if soiling was noted in the chamber and was not performed between compounding – sterile preparations (CSP). Interview with the Performance Improvement Specialist on 10/28/14 at 8:55AM noted that the pharmacist would change gloves in Isolator #1 each day the isolator was used, which was approximately once a week and that this was not documented. Manufacturer's recommendations for the IV isolators directed cleaning and disinfecting the isolator at the beginning of each shift and cleaning and sanitizing the isolator between CSP.	A749	Applies to tag A749 The isolator daily logs have been updated to include isolation unit #1 and the frequency of changing of the isolator gloves. The IV room IC policy was revised to change isolator glove changes from every other day to daily. Monitoring: The isolator logs will be audited weekly for 6 weeks to ensure compliance. Responsible Person: Director of Pharmacy	November 3, 2014 December 15, 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A749	The IV room IC policy directed that barrier isolator gloves will be changed every other day. 3. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items on the antechamber of isolator #3, sprayed the antechamber with sterile 70% isopropyl alcohol and after donning the isolators gloves/sleeves and a 20 second lapse in time, moved the items from the antechamber to the main chamber. Interview with Pharmacy Technician #1 on 10/27/14 at 2:08PM noted that, after the antechamber and items therein were sprayed with the alcohol solution, items remained in the antechamber for as long to don the isolator gloves/sleeves, enter the main chamber and transfer the items. Interview with the Director of Pharmacy on 10/27/14 at 2:05PM noted that items needed to remain in the antechamber for 15-20 seconds after the isopropyl alcohol spray. Manufacturer's recommendations for the IV isolators directed that after cleaning and decontamination, the product is to remain in the transfer chamber (antechamber) receiving a sterile shower for a period of not less than 30 seconds prior to moving them to the main working chamber.	A749		

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A749	4. A tour of the pharmacy department was conducted on 10/27/14 at 2:00 PM with the Director of Pharmacy and identified that the facility had three isolators for medication compounding. Review of the annual pharmacy IV competency evaluations identified that all staff received the annual aseptic technique test and challenge kit competency testing in the fall of 2013. The facility IV Room IC policy, revised in 1/2014, directed that all pharmacy personnel must undergo performance evaluations (competencies) including gloved fingertip sampling and medial fill testing every 12 months. Interview with the Director of Pharmacy on 10/27/14 at 2:40PM noted that staff had not yet undergone gloved fingertip sampling as competencies are conducted in the fall. According too USP 797 (2012), all compounding personnel shall successfully complete an initial competency evaluation and gloved fingertips/thumb sampling no less than 3 times before initially being allowed to compound CSPs and re-evaluation shall occur at lease annually.	A749	Applies to tag A749 All Pharmacy Compounding staff has completed glove fingertip competencies. To ensure annual compliance, glove fingertip competencies have been added to the annul Pharmacy IV Compounding competency. Monitoring: Quality Management to review Pharmacy competencies to ensure all staff has completed testing as scheduled annually. Responsible Person: Director of Pharmacy	November 30, 2014 December 12, 2014

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERJSUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
	070016	A BUILDING _____ B. WING	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP CODE
SAINT MARYS HOSPITAL	56 FRANKLIN ST WATERBURY, CT 06706

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A 000	INITIAL COMMENTS	A 000		

The following reflects the findings of the Connecticut Department of Public Healtl1 during an authorized substantial allegation survey concluded on 9l4115 in response to complaint #18731 at:

St Mary's Hospital
54 Franklin St
Waterbury, CT 06706

The following Conditions of Participation were reviewed as they pertained to the complaint:

Governing Body 482.12
QAPI 482.21
Pharmaceutical Services 482.26

Condition level noncompliance was identified under:

Governing Body 482.12
Pharmaceutical Services 482.25

Acronyms and Abbreviations that may be used throughout this document include:

MD Medical Director
NM Nurse Manager
RN Registered Nurse
Pt Patient
Tx Treatment
QAPI Quality Assurance Program Improvement
P&P Policy and Procedure
EM Environmental Monitoring

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | {XQ)DATE

Any deficiency statement ending with an asterisk e) denotes a deficiency which the Institution *may* be excused from correcting providing It Is determined that other safeguards provide sufficient protection to the patients. (See instn1clions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. for nursing homes, the above findings and plans of correction are disclosab!e 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued progran1 participation.

STATEMENT OF DEFICIENCIFS AND PIAN OF CORRECTION	(X1) PROVIOERJSIJPPUERJCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070016	A. BUILDING _____ B. WJNG	C 09/0412015

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SAINT MARYS HOSPITAL	56 FRANKLIN ST WATERBURY, CT 06706

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A 000	Continued From page 1 Definitions: USP-797: United States Pharmacopeia, Chapter 797, Requirements for licensed entities that compound sterile products. BSC: Biological safety cabinet: an enclosed, ventilated lab workspace. LAFW: Laminar flow workbench: where sterile preparations are combined under laminar air flow which is used to exclude contaminants. PEC: Primary Engineering Controls: the environment in which sterile doses of hazardous drugs are compounded. CACI: Compounding aseptic containment isolator, marked as "chemo hood", referenced in certification report. CAI: Compounding aseptic isolator PPE: Personal Protective Eq11lpment: gowns, hair covering, masks, gloves and booties that are worn by.personnel within the area of sterile compounding as directed by USP 797 standards. CFU: Colony Forming Units: a measurement of how large a mold area has grown. Certification of the rooms involve airborne non-viable particle counting (determining of ISO classification), airflow testing and smoke pattern est, room pressurization, HEPA filter leak test, general temperature and humidity. Environmental Monitoring: is a combination of	A 000		

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A 000	Continued From page 2 both the non-viable and viable testing done every 6 months. Non-viable is to determine the ISO classification. Viable testing includes surface and air sampling of the compounding areas including the hoods or PEC's (primary engineering controls). USP 797 Environmental sampling: The ES program should provide information to staff and leadership to demonstrate that the PEG Is maintaining an environment within the compounding area that consistently ensures acceptably low viable and nonviable particle levels. Environmental Sampling data shall be collected and reviewed on a periodic basis as a means of evaluating the overall control of the compounding environment.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION Is not met as evidenced by: Based on observations, a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Governing Body. The findings included: 1. The Governing body did not ensure that services offered and provided met the Medicare Conditions of Participation. Areas of noncompliance identified include: Pharmaceutical	A 043		

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A 043	Continued From page 3 Services. Refer to A·283, A-490, A-492, and A-501. 2. The Governing body failed to function effectively to ensure that culture testing was conducted In the off slte Intravenous (IV) Infusion Center by Company 111 (contracted service) prior to the initiation of compounding medications and/or failed to ensure that the contracted company provided quality services (Refer to A-83) and/or that mold/fungus growth that required the discontinuation of compounding was reported to the Governing body for review. a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold. b. Review of environmental testing completed by company **#1** (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth	A 043	Applies to Tag A 043 (a): Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Fire and Safety Surveyor and the DPH will validate all requirements of USP797 at this location prior to resuming compounding activities. Monitoring: Initial compounding date to be determined once plan for re-opening site is identified. Responsibility: Director of Pharmacy Applies to Tag A 043 (b): Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor. Monitoring: Not applicable	To Be Determined August 21, 2015

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A 043	Continued From page 4 were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3112/15, 4/30/15, and on 5/28115 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion center on that day. Interview with the Director of Pharmacy on 8/18/15 at 10:00 AM indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the surveyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained. c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 1O:1O AM indicated !hat testing within the isolator was only conducted in one area within the unit and in one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797. d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797.	A 043	Responsible Person: Manager of Ambulatory Services Applies to Tag A 043 (c): Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-opening the compounding units. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 043 (d): Environmental company asked to ensure that neutralizing specifications be added to the environmental report. Monitoring: IV Compounding Committee will review all environmental reports as they are submitted. Responsibility: Director of Pharmacy	September 30, 2015 On-going May 28, 2015 On-going

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A 043	Continued From page 5 e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dales from October 2014 lo July 23, 2015. f. On 4/30/15 and 5/28/15 mold was Identified In both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filter upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview. g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was In place to ensure quality services were provided subsequent to the identification of mold growth in the compounding **rooms.** h. In March of 2015 the daily cleaning company was changed to a Company #3, a hospital grade company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the	A 043	Applies to Tag A 043 (e): Environmental company asked to ensure that environmental reports include lot number and expiration dates. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 043 (f): A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The Committee consists of Pharmacy Management, Environmental Services, Facilities Management, Microbiologist, Infection Prevention Physician, Quality Management and Regulatory Compliance. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review. Responsibility: Director of Pharmacy	August 3, 2015 On-going August 26, 2015 On-going

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A 043	Continued From page 6 facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 Indicated that hospital staff provided the terminal cleaning which Included all surfaces in the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly. j. Interview and tour of the compounding rooms with the Director of Engineering on 8/17/15 at 10:45AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for mediations to be stored. Medications were transferred to the main hospital pharmacy on 6/13/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/11/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/14 through 6/30/15 the facility failed to have a mechanism in place to monitor the temperature of the rooms where the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendation. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room.	A 043	Applies to Tag A043 (g, h & i): Competency of contracted cleaning service, including product handling, equipment evaluation and procedure compliance to be completed. Competency of hospital staff of terminal cleaning has been completed. Monitoring: Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative. Responsibility: Director of Environmental Services Applies to A043 (j): Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms. Business plan approved, pending implementation of construction. Policy/procedure completed during survey and approved by CT Consumer Protection surveyor. Monitoring: Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly. Responsible: Manager of Ambulatory Services	Oct 15, 2015 On-going August 28, 2015 August 18, 2015 Decem ber 1, 2015

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A 043	Continued From page 7 Temperatures. k. Interview with the Manager of the Infusion Center and the Director of Engineering identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part that the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital. l. Interview and tour of the compounding rooms on 8/17/15 at 11:00 AM with the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy entitled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted. Interview with the Director of Engineering on 8/20/15 at 4:00 PM identified he was responsible to ensure a thermometer, pressure senor and exhaust fan alarms were present in the positive and negative pressure rooms and a plan for a power outage and did nol. Review of the job description for the Director of Engineering identified his/her responsibilities in part directed the management of the physical plant, electrical and medical gas delivery systems, emergency generators and project	A 043	Applies to A042 (k): Power outage policy developed during on site survey and approved by surveyor from the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management. Monitoring: Pharmacy management and Manager of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur. Responsibility: Manager of Ambulatory Services Applies to A042 (l): Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan. Pending construction implementation. Monitoring: The IV Compounding Committee to ensure the business plan for improvements is implemented. Responsibility: Director of Facilities	August 28, 2015 On-going Date of installation to be determined.

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A 043	Continued From page 8 management. In addition the Director of Engineering supervises general contractors, evaluates locates and recommends equipment and systems for replacement or upgrades, provides oversight for the development and implementation of an overall emergency management strategy for the hospital, applies practical knowledge for the operation of air conditioning and heating systems and meets with contractors to plan, organize, coordinate and communicate programs, services policies and procedures. m. During an interview on 8/18/15 at 10:30 AM, the Director of Pharmacy, the hospital's microbiologist and the Director of Facilities indicated they had meetings each time culture results were received with the Director of Environmental Services to discuss the mold/bacteria issues in the Infusion Center however, documentation did not support this. An interview with the Director of Environmental Services was unable to be scheduled as he was on a medical leave. n. During interview on 8/18/15 at 10:40 AM, the hospital microbiologist and the Director of Pharmacy identified mold issues were discussed at each monthly infection control meeting in the attendance of MD #1 who was the infection control physician. MD #1 indicated on 8/18/15 at 4:39 PM he was not aware that mold even in small amounts exceeded the USP 797 threshold. Further interview with MD #1 and the hospital mlcrobiologist Indicated that speciation was not conducted until January of 2015 and would be important for identification of the bacteria/mold to determine an appropriate action plan. MD #1 and the hospital microbiologist could identify why the	A 043	Applies to A 043 (m): Formal documentation of the meeting of the IV Compounding meeting implemented. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent the subsequent month to the Quality Committee of the Board for review. Responsibility: Manager of Clinical Quality and Regulatory Affairs Applies to A 043 (n): Speciation initiated January 2015. IV Compounding Committee will ensure that the presence of any reported mold, even in small amounts, will have an appropriate plan to address the findings.	August 26, 2015 On-going

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A 043	Continued From page 9 speciation was not conducted from September through December of 2014. Review of the infectious disease physician's duties and responsibilities included to oversee the infection control department. Interview and review *of* the Governing Body Minutes from September 2014 through June 2015 with the Chief Nursing Officer (CNO) on 8/24/15 at 1:00 PM identified the Chief Medical Officer (CMO) presented the report of the Quality and Safety Committee minutes to the Governing body however the minutes failed to reflect any acknowledgement that during that period of time, the hospital's outpatient infusion center had grown mold within the compounding areas that exceeded the USP 797 guidelines. In addition the minutes failed *to* reflect the infusion center ceased compounding on 6/30/15 due to mold in the antechamber *of* the isolator. Further interview with the CNO indicated he did not inform the Governing body of the positive cultures In the infusion center as remediation was in place and although compounding operations ceased on 6/30/15 patient care was not Interrupted. Interview with the CMO on 8/24/15 at 1:10 PM indicated he was not aware that the positive culture results in the infusion center exceeded USP 797 thresholds and/or that compounding had ceased in that area as of 6/30/15. The CMO indicated that he would have expected to be notified. Review *of* the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use of drugs.	A 043	Monitoring: Will ensure that any positive environmental reports require clinical review by the Chief of Infection Prevention with recommendations and action by the IV Compounding Committee. Responsible Person: Director of Pharmacy Applies to A043 (n) con't: Note of correction: the CMO was not interviewed. This should be amended to Chief of Staff (COS) and Chairman of the Quality Committee of the Board. Previously the Director of Pharmacy reported compounding activities quarterly to the Infection Prevention Committee which were documented and the minutes shared with the Governing Board. Immediately, Pharmacy will begin reporting compounding activities monthly to the IP Committee and the minutes will be shared with the Governing Board at the subsequent Board meeting. Monitoring: Infection Prevention minutes to be distributed at the Quality Committee of the Board. Responsible Person: Chief Nursing Officer and Vice President of Quality	On-going September 15, 2015 October 1, 2015

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A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, interviews and policy review, the Governing Body failed to ensure that quality services were rendered by contracted company's to conduct environmental testing and/or certification of the compounding rooms and/or that staff recognized that reports submitted by numerous company's were complete/accurate. The findings included: a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence from September 2014 through December 2014 that the compounding rooms were negative and positive. b. Review of the report dated 8/20/15, submitted by Company #4, to the Director of Engineering identified that the positive pressure room did not meet the minimum requirement in USP797. The room had only 0.012 of pressure and the minimum requirement is 0.02. Also, it was found that the negative pressure room was drawing air Into the room from the return in the ceiling. The Director of Engineering failed to respond to the	A 083	Applies to A 083 (a): The multi-disciplinary IV Compounding Committee will ensure adherence to USP797 protocols. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Negative and positive pressure IV compounding rooms will be tested annually per policy. All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance. Monitoring: IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance. Responsibility: Director of Pharmacy Applies to A 083 (b): Return room duct has been removed from negative pressure room. Monitoring: NA Responsible Person: Director of Facilities	October 7, 2015 On-going September 9, 2015

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A083	Continued From page 11 abnormal report. Review of the certification report test dated 9/2/14, provided the following information: c. As per the manufacturer, there are 2 supply and 2 exhaust HEPA filters (total of four) In the CACI. The test report documented that only leak tested one HEPA filter and listed the exhaust as non-applicable. There was no way to determine if the other three were leak tested before compounding began inside the CACI (chemotherapy hood), *d.* There were two chambers to the isolator with two gauges showing the pressure in each chamber (ante chamber or the pass through and compounding chamber). Only the barrier isolator pressurization or compounding chamber was documented In the certification. e. The pressure measured inside the isolator is listed as 0.34 inches of water column. A CACI Is used for chemotherapy compounding and is a negative pressure isolator as seen in the physical inspection on 8117/15 where the dials for both the chambers read negative pressure. But the report lists the pressure inside as positive pressure and incorrectly lists the manufacturer specifications as 0.01. f. The alarm assessment test is marked as not applicable. Since there is an alarm on the CACI, there is no reason given that it was not tested. g. The certification does not list If it was done under dynamic conditions as required under USP797,	A 083	Applies to A 083 **(c) through (l):** Agreement with former hood Certification Company terminated. New hood certification company agreement in place. In-service of USP797 documentation requirements to take place between hood certifier and IV Compounding Committee. Monitoring: IV compounding Committee to review all certification and environmental reports for accuracy as they are submitted. Responsible Person: Director of Pharmacy	September 15, 2015 September 30, 2015 On-going

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A 083	Continued From page 12 h. Under overall certification, the box for fail is crossed off. The pass box is filled in. There is a note that there is an issue with the units magnehelic gauge which measures the pressure inside the isolator. i. The report shows that 4 HEPA filters were leak tested-2 exhaust and 2 supply filters. According to the manufacturer there is only one supply filler. The certification does not match the manufacturer specifications. j. The alarm assessment test is marked as not applicable. Since there is an alarm on the CAI for low pressure, there is no reason given that it was not tested. k. The pressure lest indicates a negative 0.38 Inches of water column in the barrier isolator and the pass through. This is a CAI which is a positive pressure isolator therefore the pressure should not be negative. Even the manufacturer specifications are listed incorrectly as negative 0.02 for both the chambers_ l. The certification does not list if it was done under dynamic conditions as required under USP797. m. The pre-filters of the isolators are changed every 3 months. The CACI pre-filters are dated 3/25/15 of when they were changed but there is no date on the CAI prefilters. This Is done by an outside vendor that also does changes the fillers in the entire hospital. There is no way to determine when the prefilters at the off-site infusion center were changed since the invoices	A 083	Applies to A 083 (m): All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance. Monitoring: IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance. Responsibility: Manager of Ambulatory Services	October 7, 2015 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
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A 083	Continued From page 13 are done by listing all the filters changed and does not provide specifically where these filters are located. Interview with the Director of Pharmacy on 8/18/15 indicated when the certifications reports were issued, hospital staff failed to identify the aforementioned abnormalities and/or contacted company #5 (certified the isolators). At the time of this inspection, there was no report showing if the CAI had even passed certification when compounding was started on 9/4/15.	A 083		
A 283	482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk. high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas: and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

STATEMENT OF DEFICIENCIES AND PLAN Of CORRECTION	{X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER'	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
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A 283	Continued From page 14 This STANDARD is not met as evidenced by: Based on a review of hospital documentation, interviews and policies, the hospital failed to develop quality performance Improvement activities regarding high risk area's Including the IV infusion center (offsite location). The finding includes the following: The infusion center was opened by the hospital on 9/4/14. Review of environmental testing completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation al the infusion center on that day. a. Review of the Infection prevention committee meeting minutes during the period of September 2014 through June 2015 failed to indicate that surveillance activities were conducted subsequent to the identification of mold growth. Review of the Infection prevention committee functions in part. determines the mechanism for	A 283	Applies to Tag A283: A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Committee The team will be responsible for adherence to USP797 regulations. Monitoring: Activities will be reported to Infection Preventions, Pharmacy & Therapeutics Committee and the Quality Committee of the Board. Responsible Person: Director of Pharmacy	Aug 26, 2015 On-going

STATEMENT OF DIFIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CUA. IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) OATE SURVEY COMPLETED
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A 283	Continued From page 15 effective surveillance for hospital-acquired infections. Cultures would be conducted whenever necessary for environmental or patient surveillance. Recommendations for corrective actions woL1Id be implemented whenever necessary.	A 283		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Pharmaceutical Services. The findings included: 1. The hospital failed to ensure the Pharmacy department was in compliance with federal and state laws (USP-797) and/or that the Director recognized questionable performance standards provided by contracted services that provided environmental testing and certification at the IV infusion center from 9/4/14 through 6/30/15. Refer to A-492 and A-501.	A490	Applies to Tag A 490: A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. The team will be responsible for adherence to USP 797 regulations. Monitoring: Activities will be reported monthly to Infection Prevention, Pharmacy & Therapeutics and Quality Committee of the Board. Responsible Person: Director of Pharmacy	August 26, 2015 On-going
A 492	482.25(a)(1) PHARMACIST RESPONSIBILITIES A full-time, part-lime, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy	A 492		

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A 492	Continued From page 16 services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contractor reports. interviews, and policy review, the hospital failed to provide the necessary supervision of Pharmacy services to ensure that IV compounding rooms were tested/certified in accordance with federal and state laws (USP-797) and/or that culture testing was conducted prior to the initiation of compounding and/or that culture testing was comprehensive and/or that inaccurate reports were recognized and addressed. The findings include: The infusion center was opened by the hospital on 9/4/14. Review of reports completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the IV Infusion Center rooms where compounding was conducted in an isolator identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified In October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room In January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 In the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion	A 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xf) PROVIOER/SUPPL!ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 492	Continued From page 17 center on that day. a. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and inte1View with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold. b. Inte1View with the Director of Pharmacy on 8/18115 at 10:00 AM Indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus when compounding ceased, so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the su1Veyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained. c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18115 at 10:10 AM indicated that testing within the Isolator was only conducted in one area within the unit and In one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797.	A 492	Applies to Tag A 492 (a): Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Life Safety Surveyor and DPH will validate all requirements of USP797 at this location prior to resuming compounding activities. Monitoring: Initial compounding date to be determined once plan for re-opening site is identified. Responsibility: Director of Pharmacy Applies to Tag A 492 (b): Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor. Monitoring: Not applicable Responsible Person: Manager of Ambulatory Services Applies to Tag A 492 (c): Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-operationalizing the compounding units.	To be determined August 25, 2015 September 30, 2015

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A 492	Continued From page 18 d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797. e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dates from October 2014 to July 23, 2015. f. On 4/30/15 and 5/28/15 mold was identified in both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filler upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview. g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth In the compounding rooms. h. In March of 2015 the daily cleaning company was changed to a company #3, a hospital grade	A 492	Con't Tag A 492 (c): Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 492 (d): Environmental company asked to ensure that neutralizing specifications added to the environmental report. Monitoring: IV Compounding Committee will review all environmental reports as they are submitted. Responsibility: Director of Pharmacy Applies to Tag A 492 (e): Environmental company asked to ensure that environmental reports include lot number and expiration dates. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 492 (f): A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any	On-going August 3, 2015 On-going August 3, 2015 On-going August 26, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 492	Continued From page 19 company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms. i. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 indicated that hospital staff provided the terminal cleaning which included all surfaces In the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly. j. Interview and tour of the compounding rooms with Ithe Director of Pharmacy and the Director of Engineering on 8/17/15 at 10:45 AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for medications to be stored. Medications were transferred to the main hospital pharmacy on 6/30/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/1/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/15 through 6/30/15 the facility failed to have a mechanism In	A 492	Cont Tag A 492 (f): business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The IV Compounding Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review. Responsibility: Director of Pharmacy Applies to Tag A492 (g, h & i): Competency of contracted cleaning service complete, including product handling, equipment evaluation and procedure compliance. Competency of hospital staff performing terminal cleaning of IV compounding rooms completed. Monitoring: Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative Responsibility: Director of Facilities Applies to A492 (j): Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms pending business plan implementation. Policy/procedure completed during survey and approved by CT Consumer Protection surveyor.	On-going October 15, 2015 September 30, 2015 August 18, 2015

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A 492	Continued From page 20 place to monitor the temperature of the rooms were the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendations. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room Temperatures. k. interview with the Director of Pharmacy, the Manager of the Infusion Center and the Director of Engineering Identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part U1at the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital. I. Tour of the compounding rooms on 8/17/15 at 11:00 AM and interview with the Director of Pharmacy and the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy titled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted. Review of the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use	A 492	Cont' A 492 (j): Monitoring: Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly. Responsible: Manager of Ambulatory Services Applies to A492 (k): Power outage policy developed during on site survey and approved by surveyor form the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management. Monitoring: Pharmacy management and Manger of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur. Responsibility: Manager of Ambulatory Services Applies to A492 (I): Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan implementation. Pending construction implementation. Monitoring: The IV Compounding Committee to ensure the business plan for improvements is implemented.	December 1, 2015 August 28, 2015 On-going Date of installation to be determined .

PRINTED: 091211 2015
FORM APPROVED
OMB NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 492	Continued From page 21 of drugs_ Review of the job description for the Director of Pharmacy included in part the initiative to acquire knowledge, to stay currently Informed in the area and fields which are applicable to this position. Works collaboratively with other departments to meet the needs of the hospital.	A492		

EXHIBIT S4

POLICY #425.1

Subject: Saint Mary's CARE Policy

Effective Date: July 1, 2013

Revised: August 19, 2015

Replaces: Saint Mary's Financial Assistance Policy (FAP)

PURPOSE

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their ability to pay. The underlying theory is that a person, for a reasonable period of time can only be expected to pay a maximum percentage of their disposable income towards charges incurred. Any "self-pay" balance in excess of this amount would place an undue financial hardship on the patient or their family and "may" be adjusted off as Financial Assistance.

POLICY

Recognizing its charitable mission, it is the policy of the hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. Discounted care will be provided to uninsured or underinsured patients who meet the established eligibility criteria and complete the required application (all components in a timely manner) and review process.
All emergency and medically necessary services provided by this facility will be available as uncompensated services.

1. All self-pay accounts will be eligible for 40% self-pay discount, off of the published charges, regardless of their income or assets. Accounts must be in the Self-Pay Financial Class for the discount to be taken.
2. All self-pay accounts could be eligible for 100% discount if the household income is less than 200% of the Federal Poverty Level.
3. In addition to the 40% discount stated above, self-pay accounts may be eligible for an additional 25% discount, up to a maximum of 65%, if their income falls between 200% – 400% of the Federal Poverty Income level.
4. Elective cosmetic procedures are not eligible for charity care.
5. Insured patients with balances, due to deductibles, co-payments, or co-insurance, non-covered charges may be eligible for charity care if their income falls between 200% - 400% of the Federal Poverty Level.
6. Self-pay patients could be eligible for charity care write-offs based on their "Propensity to Pay".

7. A patient may only request Charity Care while the account is still active receivable.
8. Incomplete applications and falsified applications will not be considered eligible for Charity Care.
9. Patients gross income and family size will be considered in determining eligibility for Charity Care.
10. Patients found eligible for Charity Care will be eligible for care for any balance due at the time of application approval and any medically necessary services within the six months prior to application approval date and six month post date of application approval.
11. Charity Care will be given at 400% of the Federal Poverty Income levels. A sliding fee scale will be applied between 200% - 400% of the Federal Poverty Income levels.
12. Signage (in 48 or 72 font) and one page summary describing STMH charity care policy will be in English, Spanish, Portuguese, and Albanian, and placed in Registration, Emergency Department, all Social Services departments, Patient Financial Services (PFS), Cashiers office, Financial Advocate work area, and the Lobby.

DEFINITIONS:

Self-Pay
Self-pay patient is one who is financially responsible, either personally or as a guarantor, for the payment of the charges associated with the health care services provided by Saint Mary's Hospital.

Medical Necessity
Medical Necessity is, hospital care that is rendered either inpatient or outpatient, in order to diagnose, alleviate, correct, cure, or prevent the worsening or onset of a condition that endangers, could result in suffering or pain or may cause malfunction or aggravate a handicap.

Emergency Care
Emergency Care is immediate care provided to avoid causing serious jeopardy to patient's health, or causing serious impairment to body that could result in dysfunction of any organ or body parts.

Amount Generally Billed
Amount Generally Billed (AGB), means the amount generally billed to insured patients for emergent or medically necessary care as determined by the hospital's published charges at the time of billing multiplied by the hospital's most current relationship of costs to charges as taken from the hospital's most recent annual financial filing with the Office of Health Care Access.

Uninsured Patient
Saint Mary's Healthcare (SMH) defines an Uninsured Patient as:

a. Whose income is between 200% - 400% of the Federal Poverty Income levels;
b. Who has applied and been compliant in the eligibly process and has been denied eligibility for any medical or health care coverage;
c. Who is not eligible for coverage under Medicare, Tricare, or any other Federal programs, or privately sponsored health or accident insurance, including, but not limited to, workers' compensation, settlements or judgments arising from suits, claims or proceedings involving motor vehicle accidents or alleged negligence; and
d. Who is liable for one or more hospital charges.

Charity

Charity is the demonstrated inability of a patient to pay. Charity care does not include bad debt, contractual adjustments, or unreimbursed costs from other community services. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt. If the patient is able but unwilling to pay, the hospital will classify the account as bad debt.

Bad Debt
Bad debts are the unwillingness of the patient to pay. It may be included in charity care, provided the patient meet the Federal Poverty Income guidelines and provides the necessary documents, to support the income levels.

Earned Income
Earned income is the sum of all household wages or salaries received on weekly, monthly, or yearly bases.

Catastrophic Illness
Catastrophic illness is any medical condition, either acute or chronic, which incurred expenses that are not fully covered by private insurance, state, federal programs, or other sources. This will also include expenses that exceeded the patient's maximum benefits. Patient will be eligible for discount consideration, as catastrophic, if their outstanding balance exceeds 25% of their gross monthly income.

Propensity to Pay
This is the verification of patient's Ability to Pay their medical bill, based on their estimated income, and their Likelihood to Pay, based on their credit score risk. These two indicators are combined to determine appropriate financial clearance.

PROCEDURE:

1. Charity and discounted care include services provided to the following:
    a. Uninsured or underinsured low-income patients who do not have the ability to pay all or part of their bill as determined by the financial guidelines in this policy;
    b. Insured patients whose coverage is inadequate to cover a catastrophic situation;
    c. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large (as defined earlier in the definitions section) medical bills; and
    d. Patients deemed medically indigent by virtue of their documented eligibility for Medicaid benefits.

2. For emergency and medically necessary services provided to uninsured patients, and whose income are between 200% - 400% of the Federal Poverty Income Levels, SMH will reduce their bill in accordance with the guidelines provided by IRS 501(r)(5).

3. The following factors are to be considered when determining the amount of charity service for which a patient is eligible at the time of service:
    a. The patient's individual or family income, as appropriate, using the income guidelines as published by the Federal Government on April 1 each year (Federal Income Guidelines;
    b. Family size; and
    c. All other resources must be applied first, including third-party payers, Victims of Crime (i.e., a state-level program for crime victims to recover some hospital costs), and

Medicaid. If a patient does not have Medicaid but would qualify, he or she must cooperate with the application process. If the application is denied or is identified as ineligible based on the Medicaid income criteria, consider for charity and discounted care.

d. Propensity to Pay will be run as deemed necessary to qualify for charity care.

4. Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. Note: A third party might pay part of an account, the patient may pay part, and another part might meet charity services. If the patient does not pay the amount deemed to be his or her responsibility, the uncollectible remainder would become bad debt.

5. Require evidence of eligibility. Documentation should be submitted within 14 days from the date of service (to include before and after the date of service). Additional time for completion of the application process may be extended as appropriate. The patient must provide supporting documentation of income, which can include the following:
    a. Paycheck, Social Security, pension, unemployment or disability check stubs, tax return, or other proof of income.
    b. The patient must sign the charity form.

6. Charity-care provisions will be reevaluated for a patient's eligibility when the following occur, it is the patients responsibility to bring this data forth to STMH for consideration:
    a. Subsequent rendering of services;
    b. Income change;
    c. Family size change;
    d. When any part of the patient's account is written off as a bad debt or is in collections; and
    e. When six months have passed since the last application or when circumstances change, whichever comes first.

7. Determine eligibility for charity service at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.

8. Individuals who have questions about SMH charity care policy, or would like assistance with completing the application may contact our financial counselors, either in person, or by calling 203-802-8265.

9. Financial Counselors will initiate and approve/deny the application prior to submitting to the appropriate manager, based on account balance (See Number 11).

10. Patients will be notified in writing within 3 business days (Monday - Friday), from the date the "COMPLETED" application is received, regarding qualification for charity care, the remaining balance due, and any expected re-payment terms.

11. Financial Counselors will determine the write-off amount based on the aforementioned guidelines and the correct contractual allowance code. If the patient does not meet the financial criteria but has extenuating circumstances such as catastrophic illness, the account will be referred to the supervisor who will make a recommendation to the Manager/Director. Charity and discounted care

approval authority is as follows:

a. Write-offs from $.01 to $1,000 require approval by the appropriate Financial Advocate handling the account;
b. Write-offs from $1001 to $9,999 require approval by the Supervisor of Patient Access;
c. Write-offs from $10000 to $19,999 require approval by the Manager of Patient Access;
d. Write-offs $20,000 to $49,999 require approval by the Director of Patient Access;
e. Write-offs greater than $50,000 require approval by the Chief Financial Officer or Director of Finance.

12. Financial Counselors staff will ensure that patients and physicians are notified, in writing, regarding approval, denial, or pending status of uncompensated care. The notification will include the appeal process for any denied application.

13. The appeal process for denied charity and discounted care applications includes the following activities:
    a. Prompt notification of the denial and the specific reasons will be provided to each charity and discounted care applicant. The notification will also provide examples of additional information, which may be used to appeal the denial. Upon notification of the denial, the charity applicant will have 30 days to appeal the decision from the date of the denial letter.
    b. Additional information will be accepted by the provider and re-evaluated by the Supervisor/Manager.
    c. If the initial denial is upheld, prompt notification will be provided to the applicant.
    d. The Director of Patient Access or Director of Finance will review all denied appeals over $50,000. A written determination will be issued within 15 days of the receipt of the appeal.

14. The hospital will retain all charity and discounted care applications and supporting documentation within scanning for seven years.

15. The hospital will update the income eligibility criteria annually, April, using the Federal Poverty Guidelines (FPG) published by the Centers for Medicare & Medicaid Services (CMS). If CMS issues more than one update, the updated criteria shall become effective as of the issue date.

16. The base level for the charity and discount care income eligibility will be set at 40%.

17. Saint Mary's provides free x-rays and basic lab services, for patients that receive primary care services from the Malta House Van. Eligible patients are given a "Malta House" card. These services are written off at the time of billing. If patients are referred to SMH, under Malta House, for other services, they will be asked to complete a financial assistance application and if they are eligible for charity care, the charges will be adjusted appropriately. In order to prevent any billing statements being generated to these patients, a "hold" will be place on these accounts until the charity care determination is made.

18. A charity and discounted care budget will be established once a year during the annual budget process and submitted to the Board of Directors of Saint Mary's Hospital for approval. However, need for financial assistance will take priority over a fixed budget amount; the Board will be

promptly advised if charity and discounted care needs exceed the current budgetary provisions. A formal appeal process shall be implemented to permit rapid review of all appealed charity denials. The Director of Patient Access or Director of Finance shall review all final appeals of charity determinations.

References

The AHA Board of Trustees Statement of Principles and Guidelines on Hospital Billing and Collection Practices (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf);

Internal Revenue Code Section 501® requirements for tax-exempt hospitals (http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120716-legal-adv.pdf).

Creation Date: September 1, 2004
Revision Date: August 19, 2015
Key Content Expert:
JCAHO Reference:

EXHIBIT A: FINANCIAL ASSISTANCE APPLICATION

Saint Mary's HOSPITAL

Patient Name : _____ Date: _____

Current Address: Street_____

City, State, Zip _____

Phone # _____

Account(s)#: _____

Employer's Name & Address: _____

Spouse's Employer and Address: _____

Medical Insurance:_____ Policy/Claim#: _____

Insurance Company Name: _____

Address: _____

Number of Dependents (list ages, including self): _____

_____

Monthly Income (List source/amount): Patient's income_____

Spouse's income _____

Other income_____

I hereby attest that the above information is true and accurate. I understand that in order for me to be eligible, th information contained herein must be verified. I agree to provide Saint. Mary's Hospital with the necessary verifications, and, if requested by the Hospital, I agree to cooperate and follow through with application for State and/or Federal assistance as well as any other third party payors.

Patient/Guarantor: _____ Date: _____

Financial Counselor: _____ Approved by: _____ Date:_____

- All income must be verified. Please provide last 4 pay stubs.
- If you are self-employed, please provide a complete copy of last year's filed Income Tax Return (including ALL schedules (i.e. for example, Schedule C).

*Please note we will notify physicians who are part of the Franklin Medical Group of your eligibility.

Appendix B

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

Appendix C

Sliding Scale Discount Guidelines

1. Less than 200% FPL - 100%
2. 200% – 400% FPL - 65%
3. Greater than 400% - 40%

APPENDIX D: PARAGON ADJUSTMENT CODES

TYPE	CODE	DESCRIPTION	Charity or Free Care
A	48820	REDUCTION TO COST IP SELF PAY	Charity
A	48830	REDUCTION TO COST OP SELF PAY	Charity
A	48840	FREE SERVICE IP SELF PAY	Charity
A	48853	FREE SERVICE OP SELF PAY	Charity

EXHIBIT S5

Subject: **Self Pay Collection Policy**

Effective Date: 5/1/05

Revised 02/01/13

Replaces: NEW

POLICY

It is the policy of St. Mary's Hospital (SMH) that personnel will review outstanding accounts on a daily basis for timeliness of payment, and that personnel will conduct their collection activity and contact with individual patients with professionalism, courtesy and fairness.

PURPOSE

1. To ensure that policies and procedures exist for the timely and fair collection of all patient balances.

PROCEDURE

1. Admission:

All self-pay patients are interviewed by a financial counselor at the point of service. The Financial Counselor will determine if:

- The patient has any insurances that may have been overlooked;
- There is any third-party liability;
- The patient may be eligible for financial assistance, including but not limited to: Medicaid; HUSKY; a Free-Bed fund; and Charity Care;
- Accounts that are determined to be presumptively eligible for any state assistance will be moved from Self-Pay (SFPY) financial class to Welfare Pending (WLFP) financial class.
- Whenever is it determined that the patient qualifies for Charity Care, Financial Counselor will adjust the balance by the appropriate amount, and any resulting balance will become the patient's responsibility.
- If patient is deemed liable for any balance, a deposit will be requested.
- If charity care determination cannot be made, at the point of service, a deposit equal to 50% of the estimated charges will be required prior to any elective procedure.

In the event that a Financial Counselor is not available at the time of admission, they will attempt to contact patients after reviewing their admission record. Financial Counselors will attempt to visit with the patient if they are still in-house; otherwise they will call the patient's home after the patient is discharged.

2. Collection Follow-Up

A. Statements are sent to patients and/or guarantors who have outstanding balances. The timing and frequency of these statements, for both patients with a monthly payment

arrangement and those without, are based upon the statement table/schedule set up in Paragon.

- All accounts that are registered as SFPY will be transferred to Financial Health Strategies (FHS) for follow –up. SMH has contracted with FHS to operate as our Business Office for self-pay accounts. Accounts will be transferred on a daily basis. (see PARPROC for transferring procedures)
- If we get a letter from a patient quoting the Fair Debt Collection Practices Act, 15 USC 1692c, 805(c):

  (c) Ceasing Communications, "If a consumer notifies a debt collector in writing that the consumer refuses to pay a debt or that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector shall not communicate further with the consumer with respect to such debt..."

  We will notify FHS to:

  1. Stop all activity on the account.
  2. Return the account to SMH and SHM staff will refer the account to our collection agency, with a copy of the letter.

  The collection agency is expected to:

  1. Send the validation notice, to the consumer, stating that a new collector is involved.
  2. Then cease all activity and refer the account to their attorney for suit.

B. Accounts will be manually transferred to a bad debt status if one or all of the following has occurred:

- Account has been returned from FHS as part of their “Return File” marked uncollectible. FHS is required to return all accounts that have reached the timeframe of 90 days, with no payments made in the last 45 days.
- Mail is returned stamped “Moved No forwarding Address” and the account is noted as such in the system;
- There is a system note listed in the follow-up history that the third message level on the monthly statement has been mailed;
- No adequate payment has been made in the last thirty (30) days and the patient is not on a payment plan. Adequate is defined as an amount representing 10% or less of the previous balance due.

C. All attorneys representing patients in liability cases are contacted. If we are assured that the case will be settled within 120 days, the account will not be transferred to bad debt. If the settlement date requirement cannot be satisfied, the account is placed with the TCORS (Tobin, Carberry, O’Malley, Riley& Selinger) law firm so that the hospital’s interest can be protected (see TCORS procedures).

3. Bad Debts:

- Accounts are manually transferred from an active (AR) status to a bad debt status by collection personnel;

- Bad debt files are turned over weekly to a collection agency or collection attorney via electronic transfer on a weekly basis;
- Bad debts may be determined at any time during the life of the account;
- Collection personnel may make a determination to turn over an account to a collection agency at any time during the collection process;
- All accounts with a balance due AFTER a Medicare payment has been received MUST have received a minimum of four (4) patient statements over a period of greater than 120 days, and have NOT had a payment posted to the account within the last 120 days before it can be transferred to bad debt.
- Bad debt accounts for Medicare patients must be sent under a separate file to the collection agencies.

4. Settlements:

- FHS Collectors have been given the authority make settlements on accounts that are considered "reasonable". SMH management reserves the right to withdraw this authority at any time.
- SMH Customer Service personnel may offer attorneys representing patients a 5% discount for payment within thirty (30) days, provided the attorney agrees in writing to accept these terms and to discount their fees by the same amount. Any amount exceeding 5% must be approved by management.
- Occasionally, management will authorize collection personnel to offer higher discounts to patients that have previously agreed to payment plans that have had an outstanding balance for more than three (3) years in an effort to settle the account.

5. Collection Agencies:

- Accounts that are sent to bad debt will be assigned to one (1) of the two (2) agencies currently contracted with St. Mary's.
- Account are assigned based on the following Alpha categories:
  I. A - L - American Adjustment Bureau
  II. M – Z - Parallon
- Accounts can be withdrawn from the agencies at any time (see procedure for "removal of account from bad debt").
- If an account has been turned over to the collection agency for a period greater than fourteen (14) days, any request for payment arrangement or settlement must be forward to the agency.
- Collection agencies are required to returned "uncollectible accounts" that are aged greater than 150 days from the date they were transferred.
- All accounts that are returned from the agencies as uncollectible are to be written off to the following codes**: 48903 – Agency Uncollectible**
  48913 – Agency Uncollectible Medicare

6. St. Mary's Policy for Attachment of Wages & Properties

St. Mary's does not have a written agreement with any of the Collection Agencies, regarding the procedures they must follow for attachment of wages and properties. According to Outsource Group, they follow a generally accepted policy for all clients. This is a summary of their established policy:

- Account received.

- Initial dunning notice issued within 24 hours of placement.
- Phone attempt made to contact patient.
- If contact is made, the following may occur:
    1. If patient is unable to pay (unemployed, no assets, etc) the account is returned or if permission is granted by SMH, it is maintained for later follow up.
    2. If patient is bankrupt, account is closed and returned.
    3. If patient disputes charges, collection activity is suspended and proof requested from the hospital.
    4. If patient request financial assistance, collection activity is suspended and the patient is either mailed a SMH financial assistance application or given phone number to contact SMH for an application. If application is mailed to patient, SMH customer service staff is notified by phone and they are requested to document the account.
    5. If settlement is offered, authorization is sought from SMH.

- If all efforts to contact patient fail, or if patient refuses to pay, and it is verified that patient has income or assets that could be used to satisfy charges, the following steps are taken:
    1. Documentation is made of all collection efforts, including: efforts to contact patient, letters sent, income & asset verified, etc.
    2. Authorization is sought from SMH to proceed with litigation.
    3. After authorization is received, the account, along with the documentation, is forwarded to Attorney's Nathanson & Cipriano; P.O. Box 5516; Hamden, Ct 06518.

Summary of Litigation Procedure Followed by Nathanson & Cipriano's Office:

- Account received and documented. File created.
- First demand letter sent to patient.
- File reviewed and approved by Attorney.
- Signed letter sent to patient and Affidavit of Debt sent to collection agency.
- File is designated for either small claims or civil writ.
- Writ is reviewed and signed by Attorney.
- Writ sent to court; summon and complaint sent to State Marshal for service.
- If patient files an answer, case is scheduled for hearing. SMH is notified of hearing and a representative sent to the hearing.
- If no answer is filed a default judgment is entered.
- Once judgment is received, a payment plan is established in accordance with the court order.
- If patient defaults on payment plan and there is verification of employment, application is made for wage execution.
- If there is verified real estate, a judgment lien is filed. NO FORECLOSURE IS DONE ON ANY JUDGMENT LIEN.

EXHIBIT S5

Return of Organization Exempt From Income Tax

Form **990**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public.

▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning 10/01, 2013, and ending 09/30, 20 14

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization: ST. MARY'S HOSPITAL, INC.

Doing Business As:

Number and street (or P.O. box if mail is not delivered to street address): 56 FRANKLIN STREET

Room/suite:

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

D Employer identification number: 06-0646844

E Telephone number: (203) 709-6111

G Gross receipts $ 279,523,406.

F Name and address of principal officer: CHAD WABLE
56 FRANKLIN STREET WATERBURY, CT 06706-1281

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶ 0928

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.STMH.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1907 M State of legal domicile: CT

Part I Summary

1 Briefly describe the organization's mission or most significant activities: SAINT MARY'S HOSPITAL PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	20.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	16.
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1,886.
6	Total number of volunteers (estimate if necessary)	6	171.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	955,477.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	403,825.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	732,890.	1,607,114.
9	Program service revenue (Part VIII, line 2g)	239,560,411.	248,807,341.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,137,914.	4,893,950.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,876,260.	7,471,863.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	250,307,475.	262,780,268.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	7,850.	0
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	111,272,363.	109,911,511.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	120,659,761.	127,849,647.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	231,939,974.	237,761,158.
19	Revenue less expenses. Subtract line 18 from line 12	18,367,501.	25,019,110.

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	187,262,087.	187,153,109.
21	Total liabilities (Part X, line 26)	137,565,692.	140,389,197.
22	Net assets or fund balances. Subtract line 21 from line 20	49,696,395.	46,763,912.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date: 8/14/15

▶ Chad Wable President & CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: MARY-EVELYN ANTONETTI	Preparer's signature: Mary Evelyn Antonetti	Date: 8/13/2015	Check ☐ if self-employed	PTIN: P00431862
Firm's name ▶ KPMG LLP			Firm's EIN ▶ 13-5565207	
Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608			Phone no. 860-522-3200	

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

JSA
3E1010 1.000

Public Disclosure Copy

Return of Organization Exempt From Income Tax

Form **990**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public.

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OMB No. 1545-0047

2013

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- ☐ Address change
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Doing Business As:

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Room/suite:

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

D Employer identification number: 06-0646844

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G Gross receipts $ 279,523,406.

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56 FRANKLIN STREET WATERBURY, CT 06706-1281

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H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶ 0928

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

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K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

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2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

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	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	250,307,475.	262,780,268.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	7,850.	0
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	111,272,363.	109,911,511.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
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COPY FOR PUBLIC INSPECTION

		Beginning of Current Year	End of Year
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	187,262,087.	187,153,109.
	21 Total liabilities (Part X, line 26)	137,565,692.	140,389,197.
	22 Net assets or fund balances. Subtract line 21 from line 20	49,696,395.	46,763,912.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: MARY-EVELYN ANTONETTI | Preparer's signature: Mary-Evelyn Antonetti | Date: 8/13/2015 | Check ☐ if self-employed | PTIN: P00431862

Firm's name ▶ KPMG LLP | Firm's EIN ▶ 13-5565207

Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608 | Phone no. 860-522-3200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

JSA
3E1065 2.000

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
SAINT MARY'S HEALTH SYSTEM PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY. SEE SCHEDULE O.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 91,381,523. including grants of $) (Revenue $ 139,144,254.)
INPATIENT SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT SAINT MARY'S INPATIENT SERVICES PROGRAM.

4b (Code:) (Expenses $ 88,486,574. including grants of $) (Revenue $ 114,931,820.)
OUTPATIENT SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT THE OUTPATIENT SERVICES PROGRAM.

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 179,868,097.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payable to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response or note to any line in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	167		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .	2a	1,886			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)					
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			3a	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*			3b	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			4a		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			5b		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?			6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			6b		
7	**Organizations that may receive deductible contributions under section 170(c).**					
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			7a		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			8		
9	**Sponsoring organizations maintaining donor advised funds.**					
a	Did the organization make any taxable distributions under section 4966?			9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?			9b		
10	**Section 501(c)(7) organizations.** Enter:					
a	Initiation fees and capital contributions included on Part VIII, line 12	10a				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b				
11	**Section 501(c)(12) organizations.** Enter:					
a	Gross income from members or shareholders	11a				
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b				
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b				
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**					
a	Is the organization licensed to issue qualified health plans in more than one state?			13a		
	Note. See the instructions for additional information the organization must report on Schedule O.					
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b				
c	Enter the amount of reserves on hand	13c				
14a	Did the organization receive any payments for indoor tanning services during the tax year?			14a		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			14b		

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 20		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 16		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6		X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? . . .	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.	12a	X	
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12b	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12c	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	13	X	
13	Did the organization have a written whistleblower policy?	14	X	
14	Did the organization have a written document retention and destruction policy?			
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ KYLE JURCZYK 56 FRANKLIN STREET WATERBURY, CT 06706-1281 203-709-6111

Part VII **Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response or note to any line in this Part VII X

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHAD WABLE	40.00									
PRESIDENT AND CEO	10.00	X		X				755,516.	0	186,789.
(2) JOSEPH CARLSON, II	4.00									
TREASURER	4.00	X		X				0	0	0
(3) REV. MONSIGNOR JAMES COLEMAN	1.00									
VICE CHAIRMAN	4.00	X		X				0	0	0
(4) STEPHEN R. GRIFFIN, ESQ.	4.00									
SECRETARY	4.00	X		X				0	0	0
(5) JEROME SUGAR, M.D.	4.00									
CHIEF OF STAFF THRU 12/31/2013	3.00	X		X				69,625.	0	0
(6) S. MARK ALBINI, M.D.	1.00									
DIRECTOR	2.00	X						49,000.	0	0
(7) GARRETT CASEY	4.00									
DIRECTOR	2.00	X						0	0	0
(8) SISTER DOLORES LAHR	2.00									
DIRECTOR	2.00	X						0	0	0
(9) JOSEPH MENGACCI, ESQ.	4.00									
DIRECTOR	2.00	X						0	0	0
(10) WILLIAM MORRIS	1.00									
DIRECTOR THRU 12/31/2013	4.00	X						0	0	0
(11) MICHAEL O'BRIEN	1.00									
DIRECTOR	1.00	X						0	0	0
(12) DAVID ROBINSON	2.00									
DIRECTOR THRU 12/31/2013	3.00	X						0	0	0
(13) ROBERT ROSCOE	1.00									
DIRECTOR	1.00	X						0	0	0
(14) JAMES C. SMITH	4.00									
DIRECTOR	1.00	X						0	0	0

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) CHRISTINE SULLIVAN, ESQ.	1.00									
DIRECTOR	4.00	X						0	0	0
(16) JAMES UBERTI, M.D.	1.00									
DIRECTOR	40.00	X						0	205,088.	10,027.
(17) THE HONORABLE LINDA WIHBEY	1.00									
DIRECTOR (THRU 12/31/2013)	4.00	X						0	0	0
(18) MICHAEL KARNASIEWICZ, M.D.	1.00									
DIRECTOR	1.00	X						0	0	0
(19) ROBERT MAZAIKA	2.00									
CHAIRMAN (SINCE 1/1/2014)	2.00	X		X				0	0	0
(20) ERIC ALBERT	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(21) ROBERT GUMBARDO, M.D.	4.00									
DIRECTOR (SINCE 1/1/2014)	2.00	X						0	0	0
(22) ANGELA MATTIE	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(23) RICHARD PUGH	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(24) FELIX RODRIQUEZ	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(25) LAURA ST. JOHN	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
1b Sub-total ▶								874,141.	0	186,789.
c Total from continuation sheets to Part VII, Section A ▶								1,933,407.	644,871.	320,237.
d Total (add lines 1b and 1c) ▶								2,807,548.	644,871.	507,026.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 93

		Yes	No
3	Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	X	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	X	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 64

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) RALPH BECKER	40.00									
CFO (SINCE 1/27/2014)				X				0	0	0
(27) CHARLES FINN	40.00									
COO (SINCE 1/13/2014)				X				0	0	0
(28) MICHAEL NOVAK	40.00									
VP OPERATIONS					X			289,312.	0	39,546.
(29) M. CLARK KEARNEY	40.00									
VP HUMAN RESOURCES						X		249,369.	0	36,662.
(30) JOSEPH CONNOLLY	40.00									
CHIEF MARKETING OFFICER						X		185,357.	0	37,070.
(31) STEPHEN SCHNEIDER, MD	40.00									
CMO	10.00					X		0	439,783.	55,648.
(32) GREG BULLER, MD	40.00									
CHAIRMAN, DEPT. OF MEDICINE						X		255,560.	0	18,765.
(33) ELIZABETH BOZZUTO	40.00									
VP SURGICAL SERVICES						X		290,102.	0	47,790.
(34) ROBERT RILEY, CFO										
CFO (FORMER)							X	226,417.	0	32,847.
(35) SANDRA ROOSA										
VP PATIENT SVC							X	221,872.	0	36,757.
(36) CAROLYN ORRELL										
CIO (FORMER)							X	215,418.	0	5,125.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 93

		Yes	No
3	Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	X	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	X	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII X

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	75,420.			
	e	Government grants (contributions)	1e	531,694.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,000,000.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	Total. Add lines 1a-1f		1,607,114.			
Program Service Revenue			Business Code				
	2a	NET PATIENT REVENUE	900099	248,807,341.	248,807,341.		
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	Total. Add lines 2a-2f		248,807,341.			
	3	Investment income (including dividends, interest, and other similar amounts). ATTACHMENT 2		3,767,233.		-4,499.	3,771,732.
	4	Income from investment of tax-exempt bond proceeds		0			
	5	Royalties		0			
			(i) Real / (ii) Personal				
	6a	Gross rents	1,243,154.				
	b	Less: rental expenses					
	c	Rental income or (loss)	1,243,154.				
	d	Net rental income or (loss)		1,243,154.			1,243,154.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	17,869,855. / 1,172,414.				
	b	Less: cost or other basis and sales expenses	16,697,441. / 45,697.				
	c	Gain or (loss)	1,172,414. / 1,126,717.				
	d	Net gain or (loss)		1,126,717.			1,126,717.
Other Revenue	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from fundraising events		0			
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities		0			
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory		0			
		Miscellaneous Revenue	Business Code				
	11a	CAFETERIA & DIETARY	900099	1,170,616.	1,170,616.		
	b	MEANINGFUL USE	900099	2,840,267.	2,840,267.		
	c	PHYSICIAN MALPRACTICE PREMIUMS		577,645.		577,645.	
	d	All other revenue	812930	1,640,181.	1,257,850.	382,331.	
	e	Total. Add lines 11a-11d		6,228,709.			
	12	Total revenue. See instructions		262,780,268.	254,076,074.	955,477.	6,141,603.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	3,571,513.	1,785,756.	1,785,757.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	82,313,271.	70,130,907.	12,182,364.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	7,194,895.	6,024,732.	1,170,163.	
9 Other employee benefits	10,504,369.	8,795,960.	1,708,409.	
10 Payroll taxes	6,327,463.	5,298,378.	1,029,085.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	1,588,789.	397,197.	1,191,592.	
c Accounting	270,562.	67,640.	202,922.	
d Lobbying	145,704.		145,704.	
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	34,741,140.	21,286,460.	13,454,680.	
12 Advertising and promotion	568,970.	426,727.	142,243.	
13 Office expenses	9,330,115.	6,345,673.	2,984,442.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	13,337,712.	7,924,689.	5,413,023.	
17 Travel	203,873.	122,324.	81,549.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	340,398.	204,239.	136,159.	
20 Interest	1,404,558.	351,139.	1,053,419.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	9,887,837.	2,471,959.	7,415,878.	
23 Insurance	5,478,532.	3,287,119.	2,191,413.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	35,048,979.	31,544,081.	3,504,898.	
b BAD DEBT	10,078,145.	10,078,145.		
c CONSULTING	2,283,360.	1,370,016.	913,344.	
d DUES AND SUBSCRIPTIONS	852,330.	639,247.	213,083.	
e All other expenses	2,288,643.	1,315,709.	972,934.	
25 Total functional expenses. Add lines 1 through 24e	237,761,158.	179,868,097.	57,893,061.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X X

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	28,153,440.	1	24,610,433.
	2	Savings and temporary cash investments	28,942.	2	16,948.
	3	Pledges and grants receivable, net	31,774.	3	95,342.
	4	Accounts receivable, net	28,776,370.	4	26,815,465.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	-260,186.	7	-121,001.
	8	Inventories for sale or use	2,220,053.	8	3,644,672.
	9	Prepaid expenses and deferred charges	1,914,476.	9	2,489,313.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 188,967,766.			
	b	Less: accumulated depreciation — 10b: 129,200,168.	61,043,215.	10c	59,767,598.
	11	Investments - publicly traded securities ATCH 3	18,505,914.	11	20,802,742.
	12	Investments - other securities. See Part IV, line 11	46,720,286.	12	48,928,064.
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	127,803.	15	103,533.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	187,262,087.	16	187,153,109.
Liabilities	17	Accounts payable and accrued expenses	37,596,331.	17	34,904,423.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	21,332,784.	20	19,509,799.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	78,636,577.	25	85,974,975.
	26	**Total liabilities.** Add lines 17 through 25	137,565,692.	26	140,389,197.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ X and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	31,172,558.	27	27,668,208.
	28	Temporarily restricted net assets	2,269,137.	28	2,414,574.
	29	Permanently restricted net assets	16,254,700.	29	16,681,130.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	49,696,395.	33	46,763,912.
	34	Total liabilities and net assets/fund balances	187,262,087.	34	187,153,109.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	262,780,268.
2	Total expenses (must equal Part IX, column (A), line 25)	2	237,761,158.
3	Revenue less expenses. Subtract line 2 from line 1	3	25,019,110.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	49,696,395.
5	Net unrealized gains (losses) on investments	5	-527,000.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-27,424,593.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	46,763,912.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☐

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b	X	

Form 990 (2013)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

Part I **Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)
3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 ☐ An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I b ☐ Type II c ☐ Type III-Functionally integrated d ☐ Type III-Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2013

JSA
3E1210 1.000

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)** (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(03) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 80,420.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 191,245.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 340,449.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part III ***Exclusively*** **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $ _____

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
▶ See separate instructions. ▶ Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures . . . . . ▶ $
3 Volunteer hours . . . . . .

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 . . . . . ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . . . ☐ Yes ☐ No
4a Was a correction made? . . . . . ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? . . . . . ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

	(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		145,704.
j Total. Add lines 1c through 1i			145,704.
2 a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		X	

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

		Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1		
2 Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a Current year	2a	
b Carryover from last year	2b	
c Total	2c	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5 Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

SCHEDULE C - PART II-B - LINE 1I

$1,402 - THE CATHOLIC HEALTH ASSOCATION - ANNUAL MEMBERSHIP DUES

$90,000 - LEGAL FEES RELATED TO LOBBYING

$35,802 - CONNECTICUT HOSPITAL ASSOCIATION - PORTION OF MEMBERSHIP DUES EXPENDED ON LOBBYING

$18,500 - COMPENSATION OF CHIEF MARKETING OFFICER ATTRIBUTABLE TO LOBBYING (APPROXIMATELY 10% OF OFFICER TIME SPENT ON LOBBYING ACTIVITIES)

TOTAL OTHER LOBBYING ACTIVITIES: $145,704

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990.

▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	16,630,000.	15,567,000.	13,783,000.	14,500,000.	13,893,000.
b Contributions					
c Net investment earnings, gains, and losses	1,264,000.	1,768,000.	2,426,000.	-64,000.	1,286,000.
d Grants or scholarships					
e Other expenditures for facilities and programs	756,000.	705,000.	642,000.	653,000.	679,000.
f Administrative expenses					
g End of year balance	17,138,000.	16,630,000.	15,567,000.	13,783,000.	14,500,000.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ 2.6700 %
c Temporarily restricted endowment ▶ 97.3300 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		7,272,019.		7,272,019.
b Buildings		65,301,177.	48,126,290.	17,174,887.
c Leasehold improvements				
d Equipment		115,755,461.	80,754,037.	35,001,424.
e Other		639,108.	319,840.	319,268.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				59,767,598.

Part VII Investments - Other Securities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests	5,181,551.	ATTACHMENT 1
(3) Other		
(A) DONOR & HELD IN TRUST BY OTHER	15,696,295.	FMV
(B) DEBT SERVICE FUND	4,321,505.	FMV
(C) MISCELLANEOUS FUNDS	5,613.	FMV
(D) INVESTMENTS IN JOINT VENTURES	23,723,100.	FMV
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	48,928,064.	

Part VIII Investments - Program Related.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶		

Part IX Other Assets.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO REIMBURSEMENT AGENCIES	782,612.
(3) SELF INSURANCE LIABILITY	3,278,452.
(4) PENSION LIABILITY	72,181,823.
(5) OTHER LONG TERM LIABILITIES	9,463,675.
(6) OTHER LONG TERM DEBT (CAPITAL	268,413.
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	85,974,975.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines 2a through 2d			2e	
3	Subtract line 2e from line 1			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines 2a through 2d			2e	
3	Subtract line 2e from line 1			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information.
Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

PART V, LINE 4

THE INTENDED USE OF THE ENDOWMENT FUNDS IS TO USE THE INCOME GENERATED TO SUPPORT THE MISSION OF THE HOSPITAL. THE HOSPITAL ADOPTED INVESTMENT AND SPENDING POLICIES FOR ENDOWMENT ASSETS THAT ATTEMPT TO PROVIDE A PREDICTABLE STREAM OF FUNDING TO PROGRAMS SUPPORTED BY ITS ENDOWMENT WHILE SEEKING TO MAINTAIN THE PURCHASING POWER OF THE ENDOWMENT ASSETS. THE HOSPITAL FOLLOWS A POLICY OF SPENDING AN AMOUNT THAT APPROXIMATES THE INVESTMENT INCOME EARNED, IN ADDITION TO SPECIFIC PURCHASES OF CAPITAL EQUIPMENT. ACCORDINGLY, THE HOSPITAL EXPECTS ITS SPENDING POLICY WILL ALLOW ITS ENDOWMENT FUNDS TO BE MAINTAINED IN PERPETUITY BY GROWING AT A RATE AT LEAST EQUAL TO THE PLANNED PAYOUTS. ADDITIONAL REAL ENDOWMENT GROWTH WILL BE PROVIDED THROUGH NEW GIFTS AND ANY EXCESS INVESTMENT RETURN.

PART X, LINE 2

THE HOSPITAL IS A TAX-EXEMPT ORGANIZATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS GENERALLY EXEMPT FROM INCOME TAXES. THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS HAVE BEEN PREPARED ON THE BASIS THAT ITS TAX-EXEMPT STATUS WILL BE MAINTAINED.

THE INDEMNITY COMPANY AND PHYSICIAN PARTNERS ARE DISREGARDED ENTITIES. THE TAX CONSEQUENCES OF THEIR OPERATING RESULTS ARE ASSESSED AT THE MEMBER LEVEL.

THE HOSPITAL RECOGNIZES THE EFFECT OF INCOME TAX POSITIONS ONLY IF THOSE POSITIONS ARE MORE LIKELY THAN NOT OF BEING SUSTAINED. RECOGNIZED INCOME

Part XIII Supplemental Information *(continued)*

TAX POSITIONS ARE MEASURED AT THE LARGEST AMOUNT OF BENEFIT THAT IS GREATER THAN FIFTY PERCENT LIKELY TO BE REALIZED UPON SETTLEMENT. CHANGES IN RECOGNITION IN MEASUREMENT ARE REFLECTED IN THE PERIOD IN WHICH THE CHANGE IN JUDGMENT OCCURS. THE HOSPITAL DID NOT RECOGNIZE THE EFFECT OF ANY INCOME TAX POSITIONS IN EITHER 2014 OR 2013.

ATTACHMENT 1

SCHEDULE D, PART VII - INVESTMENTS - CLOSELY HELD EQUITY INTERESTS

DESCRIPTION	BOOK VALUE	COST OR FMV
NET INTEREST IN FOUNDATION	5,181,551.	FMV
TOTALS	5,181,551.	

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 250.0000 %	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other ____%	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			328,346.		328,346.	.14
b Medicaid (from Worksheet 3, column a)			68,868,328.	55,785,133.	13,083,195.	5.75
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			69,196,674.	55,785,133.	13,411,541.	5.89
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			147,207.		147,207.	.06
f Health professions education (from Worksheet 5)			19,733,222.	17,074,901.	2,658,321.	1.17
g Subsidized health services (from Worksheet 6)			3,622,131.	2,236,001.	1,386,130.	.61
h Research (from Worksheet 7)			165,239.		165,239.	.07
i Cash and in-kind contributions for community benefit (from Worksheet 8)			70,911.		70,911.	.03
j Total. Other Benefits			23,738,710.	19,310,902.	4,427,808.	1.94
k Total. Add lines 7d and 7j			92,935,384.	75,096,035.	17,839,349.	7.83

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing			202.		202.	
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			169,504.		169,504.	
9 Other						
10 Total			169,706.		169,706.	

Part III **Bad Debt, Medicare, & Collection Practices**

			Yes	No
Section A. Bad Debt Expense				
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	3,295,553.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	2,306,887.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				
Section B. Medicare				
5 Enter total revenue received from Medicare (including DSH and IME)	5	94,305,076.		
6 Enter Medicare allowable costs of care relating to payments on line 5	6	86,782,623.		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	7,522,453.		
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				
Section C. Collection Practices				
9a Did the organization have a written debt collection policy during the tax year?	9a		X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	H. L. CANCER CTR	OUTPATIENT CANCER TREATMENT	50.00000		
2	HEART CTR OF FW	CARDIAC SERVICES MSO	50.00000		
3	SM INDEMNITY GROUP	INSURANCE COMPANY	100.00000		
4	FRANKLIN MEDICAL	PRIMARY CARE PHYSICIAN PRACT			100.00000
5	DIAGNOSTIC IMAGING	OUTPATIENT IMAGING CENTER	60.00000		
6	NAUGATUCK VALLEY MRI	MAGNETIC IMAGING	48.00000		
7	SM PHYSICIAN PTRS.	ACCOUNTABLE CARE ORG.	100.00000		
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 SAINT MARY'S HOSPITAL INCORPORATED 56 FRANKLIN STREET WATERBURY CT 06706	X	X		X			X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group SAINT MARY'S HOSPITAL INCORPORATED

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)

			Yes	No
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9.	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url):			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[X] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy SAINT MARY'S HOSPITAL INCORPORATED

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 250 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[X] State regulation			
h	[ ] Residency			
i	[ ] Other (describe in Section C)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Section C)			

Billing and Collections

15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* SAINT MARY'S HOSPITAL INCORPORATED

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a [X] Notified individuals of the financial assistance policy on admission
- b [X] Notified individuals of the financial assistance policy prior to discharge
- c [X] Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d [X] Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e [ ] Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	

If "No," indicate why:

- a [ ] The hospital facility did not provide care for any emergency medical conditions
- b [ ] The hospital facility's policy was not in writing
- c [ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d [ ] Other (describe in Section C)

Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a [ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b [ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c [ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d [X] Other (describe in Section C)

21	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
22	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

PART V, LINE 20D

FREE CARE IS PROVIDED FOR UNINSURED INDIVIDUALS WHOSE INCOME IS BELOW 250% OF THE FEDERAL POVERTY INCOME LEVELS. FOR UNINSURED PATIENTS WHOSE INCOME ARE BETWEEN 251% AND 350% OF THE FEDERAL POVERTY INCOME LEVELS, SMH WILL REDUCE THEIR BILL BY SLIDING SCALE DISCOUNT OR TO "COST OF PROVIDING SERVICES", AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OHCA), WHICHEVER IS GREATER.

UNINSURED PATIENTS, WHOSE INCOME RANGE BETWEEN 351% AND 400% OF THE FEDERAL POVERTY INCOME LEVELS, WILL BE ELIGIBLE FOR AN ADDITIONAL CHARITY CARE REDUCTION OF 20% OFF OF THEIR REMAINING ACCOUNT(S) BALANCE(S).

PART V, LINE 3

SAINT MARY'S RECEIVED SIGNIFICANT INPUT FROM PERSONS REPRESENTING THE COMMUNITY. THE ASSESSMENT WAS CONDUCTED IN COLLABORATION WITH THE NEWLY FORMED GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (GWHIP), WHICH INCLUDES SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION. IN ADDITION, GWHIP HOSTED A PRIORITIZATION SESSION THAT INCLUDED 41 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. AT THIS PRIORITIZATION SESSION WHICH TOOK PLACE ON JUNE 18, 2013, THE GROUP VOTED ON COMMUNITY HEALTH PRIORITIES.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

THE SESSION INCLUDED 41 PARTICIPANTS FROM 29 ORGANIZATIONS INCLUDING BUT NOT LIMITED TO WATERBURY BOARD OF PUBLIC HEALTH, CATHOLIC CHARITIES ARCHDIOCES OF HARTFORD, UCONN SCHOOL OF PUBIC HEALTH, END HUNGER CONNECTICUT, VNA HEALTH-AT-HOME, BRIDGE TO SUCCESS, HEART CENTER OF GREATER WATERBURY AND THE CHAMBER OF COMMERCE. A LISTING OF PARTICIPANTS IS AVAILABLE UPON REQUEST.

PART V, LINE 4

WATERBURY HOSPITAL

PART V, LINE 5C

GWHIP HOSTED A "HEALTH SUMMIT" AT NAUGATUCK VALLEY COMMUNITY COLLEGE ON OCTOBER 4, 2013. MEMBERS OF THE PUBLIC WERE INVITED TO ATTEND. OVER 100 PEOPLE ATTENDED THE EVENT.

AT THE HEALTH SUMMIT, GWHIP REPRESENTATIVES PRESENTED THE CHNA FINDINGS. GWHIP ALSO CONVENED WORK GROUPS TO ADDRESS IDENTIFIED AREAS OF COMMUNITY HEALTH NEED.

PART V, LINE 7

SAINT MARY'S HOSPITAL ADMINISTRATORS DECIDED TO FOCUS ON THE TOP FOUR COMMUNITY HEALTH NEEDS (ACCESS TO CARE; MENTAL HEALTH/SUBSTANCE ABUSE; CHRONIC DISEASES (OBESITY, HEART DISEASE, DIABETES, AND ASTHMA); AND TOBACCO USE). THESE NEEDS WERE SELECTED AT THE "PRIORITIZATION SESSION" THAT WAS HELD ON JUNE 18, 2013.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

DUE TO LIMITED TIME AND RESOURCES, SAINT MARY'S IS UNABLE TO ADDRESS EACH IDENTIFIED COMMUNITY HEALTH NEED. COMMUNITY ORGANIZATIONS ARE ADDRESSING THE OTHER IDENTIFIED HEALTH NEEDS. FOR EXAMPLE, THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ARE BOTH ADDRESSING "LOW BIRTH WEIGHT" BABIES THROUGH THE WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITION PROGRAM. THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ADMINISTER THE WIC PROGRAM LOCALLY.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 9

	Name and address	Type of Facility (describe)
1	NAUGATUCK VALLEY SURGICAL CENTER 160 ROBBINS STREET, SUITE 1 WATERBURY CT 06708	SURGICAL CENTER
2	THE HAROLD LEEVER CANCER CENTER 1075 CHASE PARKWAY WATERBURY CT 06708	CANCER CENTER
3	SAINT MARY'S MEDICAL IMAGING CENTER 475 CHASE PARKWAY WATERBURY CT 06708	MRI SERVICES
4	SLEEP DISORDER CENTER 1312 WEST MAIN STREET WATERBURY CT 06708	SLEEP CARE
5	OCCPUATION HEALTH & DIAG. CENTER 146 HIGHLAND AVENUE WATERBURY CT 06708	OCCUPATIONAL HEALTH, OCCUPATIONAL THERAPY, PHYSICAL THERAPY
6	HEART CENTER OF GREATER WATERBURY 1075 CHASE PARKWAY WATERBURY CT 06708	CARDIAC CARE
7	ST. MARY'S HOSP. URGENT CARE - NAUGATUCK 799 NEW HAVEN ROAD NAUGATUCK CT 06770	LAB, RADIOLOGY, URGENT CARE
8	ST. MARY'S HOSP. URGENT CARE - WOLCOTT 503 WOLCOTT ROAD WOLCOTT CT 06716	LAB, RADIOLOGY, URGENT CARE
9	ST. MARY'S MEDICAL ONCOLOGY CENTER 1075 CHASE PARKWAY WATERBURY CT 06708	ONCOLOGY
10		

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 6A

SAINT MARY'S HOSPITAL COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING THE FISCAL YEAR ENDED 9/30/2013. THE CHNA IS ACCESSIBLE BY CLICKING "ABOUT US" AND "HEALTH NEEDS ASSESSMENT BUTTON" ON THE SAINT MARY'S WEBSITE AT WWW.STMH.ORG.

PART I, LINE 7A

MANY PATIENTS WITHOUT INSURANCE DO NOT COMPLETE THE APPLICATION FOR CHARITY CARE. THE HOSPITAL, UPON PERFORMING AN ASSET VERIFICATION, MAKES A DETERMINATION WHETHER THE PATIENT WOULD HAVE QUALIFIED FOR THE CHARITY CARE. DURING 2012, THE COSTS ASSOCIATED WITH THE CHARGES FOREGONE RELATED TO THESE PATIENTS WERE APPROXIMATELY $1,340,000. DURING 2013 AND 2014, A SYSTEM CONVERSION LIMITED THE HOSPITAL'S ABILITY TO UNDERTAKE AN ASSET VERIFICATION. AS SUCH, THESE COSTS ARE CLASSIFIED IN THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS. THE HOSPITAL BELIEVES THAT HAD IT PERFORMED THE ASSET VERIFICATIONS IN 2014, COSTS ASSOCIATED WITH THESE PATIENTS WOULD HAVE BEEN FAIRLY CONSISTENT WITH 2012.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7, COLUMN F

THE PERCENT OF TOTAL EXPENSE IN PART 1, LINE 7, COLUMN (F) IS CALCULATED BY DIVIDING COLUMN (E), NET COMMUNITY BENEFIT EXPENSE, BY TOTAL EXPENSE. THE BAD DEBT EXPENSE OF $10,078,145 WAS SUBTRACTED FROM THE TOTAL EXPENSE VALUE USED TO CALCULATE THE PERCENTAGES IN PART 1, LINE 7, COLUMN (F).

PART I, LINE 7

FOR PART 1, LINE 7 SECTIONS (A) CHARITY CARE AT COST, (B) UNREIMBURSED MEDICAID, (C) UNREIMBURSED COSTS-OTHER MEANS-TESTED GOVERNMENT PROGRAMS THE COSTING METHODOLOGY USED WAS THE COST-TO-CHARGE RATIO USING THE INCOME STATEMENT METHOD. THE COST-TO-CHARGE RATIO WAS DERIVED FROM THE YEAR-END GENERAL LEDGER, CALCULATED BY DIVIDING GROSS EXPENSE (LESS BAD DEBT) MINUS OTHER OPERATING REVENUE BY GROSS PATIENT CHARGES AND APPLIED BY CHARGE LINE APPROPRIATELY. SECTIONS (E) COMMUNITY HEALTH IMPROVEMENT; PORTIONS OF (F) HEALTH PROFESSIONS EDUCATION, (G) SUBSIDIZED HEALTH SERVICES, (H) RESEARCH, AND (I) CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS ARE COMPRISED (EXCEPT FOR CASH DONATIONS AND IN-KIND MATERIAL DONATIONS) OF 1) SUPPLY EXPENSES; 2) PURCHASED SERVICES; 3)

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TUITION WAIVERS; AND 4) THE DIRECT SALARY COSTS FOR STAFF COMPENSATED BY THE HOSPITAL AND SPENT TIME PARTICIPATING IN ACTIVITIES THAT QUALIFY AS COMMUNITY BENEFITS.

THE INTERN, RESIDENT AND FELLOW PORTION OF SECTION (F) HEALTH PROFESSIONS EDUCATION ALSO INCLUDES THE SALARIES, FRINGE BENEFITS AND OTHER EXPENSES OF THE RESIDENCY PROGRAM DERIVED FROM THE GENERAL LEDGER. INDIRECT COSTS WERE ALSO APPLIED. THE COST ACCOUNTING METHODOLOGY WAS USED TO DETERMINE NET COMMUNITY BENEFIT EXPENSE FOR (G) SUBSIDIZED HEALTH SERVICES, WHICH INCLUDE IP AND OP PSYCHIATRY SERVICE LINES AND SERIES/RECURRING.

PART III, LINE 4

THE FINANCIAL STATEMENTS DO NOT HAVE A FOOTNOTE FOR BAD DEBT EXPENSE BUT BELOW IS THE FOOTNOTE FOR THE ALLOWANCE FOR BAD DEBTS.

THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER THEIR FINANCIAL ASSISTANCE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN THEIR ESTABLISHED RATES. BECAUSE THE HOSPITAL DOES NOT ANTICIPATE

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COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. THE HOSPITAL GRANTS CREDIT WITHOUT COLLATERAL TO PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY ARRANGEMENTS. ADDITIONS TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ARE MADE BY MEANS OF THE FOR BAD DEBTS. ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE AND SUBSEQUENT RECOVERIES ARE ADDED. THE AMOUNT OF THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENTAL HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS.

PART III, SECTION A: LINES 2 & 3

THE HOSPITAL USED A COST TO CHARGE RATIO TO CALCULATE THE AMOUNTS RECORDED IN LINES 2 AND 3. WE REASONABLY ESTIMATED THE AMOUNT OF BAD DEBTS THAT WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S CHARITY CARE POLICY, IF THE PATIENTS WOULD HAVE APPLIED OR PROVIDED SUFFICIENT INFORMATION. WE DID NOT INCLUDE THIS AMOUNT IN THE COMMUNITY BENEFIT.

Part VI Supplemental Information

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PART III, LINE 8

THERE IS NO SHORTFALL REPORTED IN LINE 7, THEREFORE, WE DID NOT INCLUDE IN COMMUNITY BENEFIT. WE UTILIZED THE COST TO CHARGE RATIO TO ESTIMATE THE MEDICARE ALLOWABLE COSTS OF CARE.

PART III, LINE 9B

A PATIENT MAY REQUEST CHARITY CARE AT ANY TIME IN THE BILLING AND COLLECTION PROCESS. IF THE HOSPITAL, ITS COLLECTION AGENT, OR ITS ATTORNEY BECOMES AWARE THAT THE PATIENT OR GUARANTOR REQUESTS CHARITY CARE, THE COLLECTION PROCESS WILL BE PROMPTLY DISCONTINUED WHILE THE ELIGIBILITY STATUS OF THE PATIENT OR GUARANTOR REQUESTING ASSISTANCE IS DETERMINED. WHENEVER IT IS DETERMINED THAT THE PATIENT QUALIFIES FOR CHARITY CARE, THE FINANCIAL COUNSELOR WILL ADJUST THE BALANCE BY THE APPROPRIATE AMOUNT, AND ANY RESULTING BALANCE WILL BECOME THE PATIENT'S RESPONSIBILITY.

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PART VI, LINE 2

SAINT MARY'S HAS AN ANNUAL STRATEGIC PLANNING PROCESS THAT IDENTIFIES UNMET COMMUNITY NEEDS WHILE DEPLOYING STRATEGIES TO ADDRESS THESE UNMET COMMUNITY NEEDS AND IMPROVE OUR OVERALL COMMUNITY BENEFIT. SAINT MARY'S ALSO WORKS CLOSELY WITH MANY LOCAL CHARITABLE COMMUNITY SERVICE ORGANIZATIONS TO BOTH IDENTIFY AND ADDRESS COMMUNITY NEEDS.

SAINT MARY'S HOSPITAL (SMH) INDIVIDUAL COMMUNITY BENEFIT PROGRAMS HAVE BEEN DESIGNED TO MEET THE LONG-STANDING NEEDS OF INDIVIDUALS LIVING IN THE SERVICE AREA. TO IDENTIFY NEED, SMH HAS RELIED ON EXISTING LOCAL AND REGIONAL NEEDS ASSESSMENTS INCLUDING: UNITED WAY OF GREATER WATERBURY'S COMMUNITY STATUS REPORT (2013); UNITED WAY'S TEN-YEAR PLAN TO END HOMELESSNESS (2013); THE CENTERS FOR DISEASE CONTROL AND PREVENTION BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (2013); CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STATE HEALTH ASSESSMENT (2013); AND THE CONNECTICUT HEALTH CARE SURVEY (2013) BY THE CONNECTICUT HEALTH FOUNDATION.

IN ADDITION, THE HOSPITAL USES CONNECTICUT HOSPITAL ASSOCIATION (CHA)

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ONLINE TOOLS WHICH INCLUDE THE CHIME DECISION SUPPORT TOOL AND CHIME MAPS TO UNDERSTAND SERVICE AREA NEEDS. THE HOSPITAL USES THE CENSUS BUREAU DATABASES AS WELL AS DEMOGRAPHIC REPORTS AVAILABLE THROUGH CLARITAS DATABASES.

BETWEEN 2012 AND 2013, SAINT MARY'S CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). SAINT MARY'S REACHED OUT TO LOCAL ORGANIZATIONS AND FORMED THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (THE PARTNERSHIP). THE PARTNERSHIP INCLUDES LOCAL NON-PROFIT ORGANIZATIONS (SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION). PARTNERSHIP MEMBERS EACH CONTRIBUTED FINANCIAL RESOURCES TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT.

DATA COLLECTION AND RESEARCH

SAINT MARY'S CONTRACTED WITH HOLLERAN, AN INDEPENDENT RESEARCH AND CONSULTING FIRM LOCATED IN LANCASTER, PENNSYLVANIA, TO CONDUCT RESEARCH IN SUPPORT OF THE CHNA. THE CHNA INCLUDED BOTH QUALITATIVE AND

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QUANTITATIVE DATA COLLECTION METHODS. QUALITATIVE DATA WERE COLLECTED THROUGH BOTH A KEY INFORMANT ONLINE SURVEY AND SIX FOCUS GROUPS. TWO HUNDRED FIVE COMMUNITY LEADERS, PARTNERS AND HEALTH CARE PROVIDERS PARTICIPATED IN THE ONLINE KEY INFORMANT SURVEY. TWO FOCUS GROUPS WITH HEALTHCARE PROVIDERS WERE HELD AT EACH OF THE HOSPITALS; 24 HEALTH CARE PROVIDERS PARTICIPATED. FOUR FOCUS GROUPS WERE HELD AT NEIGHBORHOOD ASSOCIATIONS IN WATERBURY; 33 LOCAL RESIDENTS PARTICIPATED.

QUANTITATIVE DATA WERE COLLECTED THROUGH A STATISTICAL HOUSEHOLD TELEPHONE SURVEY OF 1,100 PEOPLE IN THE SAINT MARY'S SERVICE AREA. THE STATISTICAL HOUSEHOLD SURVEY WAS BASED ON THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) STUDY DEVELOPED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC). THE SURVEY ASSESSED INDICATORS SUCH AS GENERAL HEALTH STATUS, PREVENTION ACTIVITIES (SCREENINGS, ETC.) AND RISK BEHAVIORS (ALCOHOL USE, ETC.). THE RESULTS WERE EXAMINED BY A VARIETY OF DEMOGRAPHIC INDICATORS INCLUDING AGE AND GENDER. SPECIAL ATTENTION WAS GIVEN TO IDENTIFYING THE NEEDS OF UNDERSERVED INDIVIDUALS, INCLUDING LOW-INCOME, MINORITY, AND CHRONIC CONDITION POPULATIONS IN THE SAINT

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MARY'S SERVICE AREA. IN ADDITION TO THE HOUSEHOLD SURVEY, SECONDARY DATA WERE ALSO ANALYZED AS PART OF THE CHNA.

PRIORITIZATION

ON JUNE 18, 2013, THE PARTNERSHIP HELD A PRIORITIZATION SESSION THAT INCLUDED 40 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. THE OBJECTIVES OF THE PRIORITIZATION SESSION WERE TO REVIEW THE RECENTLY COMPILED COMMUNITY HEALTH DATA AND HIGHLIGHT KEY RESEARCH FINDINGS; TO GATHER FEEDBACK FROM THE COMMUNITY REPRESENTATIVES; AND TO PRIORITIZE THE COMMUNITY HEALTH NEEDS BASED ON SELECTED CRITERIA.

ATTENDEES VOTED ON THE TOP FOUR PRIORITY AREAS. THE SELECTED PRIORITIES ARE (1) ACCESS TO CARE; (2) MENTAL HEALTH AND SUBSTANCE ABUSE; (3) CHRONIC DISEASES - OBESITY, DIABETES, HEART DISEASE AND ASTHMA; AND (4) SMOKING.

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IMPLEMENTATION STRATEGY

SAINT MARY'S HOSPITAL DEVELOPED AN IMPLEMENTATION STRATEGY TO ILLUSTRATE SPECIFIC PROGRAMS AND RESOURCES THAT SUPPORT THESE IDENTIFIED COMMUNITY HEALTH PRIORITIES. THE IMPLEMENTATION STRATEGY WAS ADOPTED BY THE SAINT MARY'S BOARD OF DIRECTORS ON SEPTEMBER 12, 2013. THE IMPLEMENTATION STRATEGY IS ATTACHED TO THIS FILING. THE CHNA SUMMARY REPORT AND IMPLEMENTATION STRATEGY ARE ALSO AVAILABLE ON THE HOSPITAL'S WEBSITE (WWW.STMH.ORG).

ONCE THE IMPLEMENTATION STRATEGY WAS CREATED, CONTINUED MONTHLY MEETINGS WITH THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP WERE DONE TO ENSURE TAHT EACH ORGANIZATION STAYED ON TRACK WITH THE NEEDS OF THE COMMUNITY. THERE ARE SEVERAL REPRESENATIVES FROM SAINT MARY'S THAT ATTEND THESE MEETINGS EACH MONTH TO NOT ONLY IMPROVE THE HOSPITAL WITH INCREMENTAL CHANGES, BUT THE GREATER WATERBURY COMMUNITY AS A WHOLE. CONTINUED COLLABORATION AND MANAGEMENT OF THE IMPLEMENTATION STRATEGIES ARE DISCUSSED WITH THE COMMUNITY PARTNERS EACH MONTH.

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PART VI, LINE 3

THERE ARE BROCHURES AND SIGNAGE IN FOUR LANGUAGES INDICATING THAT FINANCIAL ASSISTANCE IS AVAILABLE TO QUALIFIED PATIENTS AND THEIR FAMILIES. SIGNAGE IS LOCATED IN REGISTRATION, EMERGENCY DEPARTMENT, ALL SOCIAL SERVICES DEPARTMENTS, CASHIER'S OFFICE, PATIENT FINANCIAL SERVICES AND THE LOBBY. THE SIGNAGE EXPLAINS THE POLICY AND HOW TO APPLY. IN ADDITION, FINANCIAL COUNSELORS ARE AVAILABLE TO MEET WITH INDIVIDUAL PATIENTS TO ASSIST DURING THE PROCESS.

ALL FAMILIES OF ELIGIBLE CHILDREN, REGARDLESS OF INCOME, RECEIVE CARE COORDINATION SERVICES IN PARTNERSHIP WITH THEIR CHILD'S MEDICAL HOME UNDER THE SAINT MARY'S PROGRAM. FAMILY AND COMMUNITY REFERRALS, DIRECT SERVICES, ADVOCACY AND LINKS TO PARENT SUPPORT SERVICES ARE ALSO PROVIDED. A LIMITED NUMBER OF FAMILIES RECEIVE RESPITE AND CAMP FUNDS. UNINSURED OR UNDERINSURED FAMILIES WHO FALL WITHIN THE TITLE V EXTENDED SERVICE FUNDS ELIGIBILITY GUIDELINES CAN ALSO BENEFIT FROM PAYMENT FOR EXTENDED SERVICES (I.E. DURABLE MEDICAL EQUIPMENT, PRESCRIPTIONS,

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SPECIALTY VISITS, THERAPIES AND SPECIAL NUTRITIONAL FORMULAS).

PATIENT FINANCIAL AID SAINT MARY'S HOSPITAL PROVIDES FINANCIAL ASSISTANCE TO PATIENTS WHO QUALIFY FOR THE HOSPITAL'S "BED FUND" OR OTHER FINANCIAL ASSISTANCE PROGRAMS.

IF A PATIENT IS UNINSURED OR OTHERWISE UNABLE TO PAY HIS OR HER MEDICAL BILLS, HE OR SHE MAY QUALIFY FOR THE HOSPITAL BED FUND. IN ORDER TO QUALIFY, A PATIENT MUST MEET CERTAIN CRITERIA, INCLUDING HAVING A HOUSEHOLD INCOME AT OR BELOW 400% OF THE FEDERAL POVERTY LIMITS.

IF A PATIENT QUALIFIES FOR THE "BED FUND," OR ANY OTHER FINANCIAL ASSISTANCE PROGRAMS, THE PATIENT WILL BE NOTIFIED WITHIN THIRTY (30) DAYS OF RECEIPT OF APPLICATION. IF A PATIENT'S APPLICATION IS DENIED, AN EXPLANATION WILL BE PROVIDED. THE PATIENT MAY REAPPLY AT ANY TIME AND THE APPLICATION WILL BE REASSESSED BASED ON THE AVAILABILITY OF ADDITIONAL FUNDS OR A CHANGE IN THE PATIENT'S FINANCIAL STATUS.

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PART VI, LINE 4

SAINT MARY'S TOTAL SERVICE AREA IS COMPRISED OF 35 ZIP CODES, WHICH INCLUDE THE CITY OF WATERBURY AND 17 SURROUNDING TOWNS. THE PRIMARY SERVICE AREA (WHICH INCLUDES WATERBURY, NAUGATUCK, PROSPECT AND WOLCOTT, CT) HAS A POPULATION OF APPROXIMATELY 165,400. THE SECONDARY SERVICE AREA HAS A POPULATION OF APPROXIMATELY 144,600. THE MAJORITY OF SAINT MARY'S HOSPITAL PATIENTS LIVE IN THE CITY OF WATERBURY WHICH IS PARTICULARLY ECONOMICALLY DISTRESSED. THE MEDIAN HOUSEHOLD INCOME IS $40,867, WHICH IS SIGNIFICANTLY LESS THAN THE OVERALL SERVICE AREA, WHICH IS APPROXIMATELY $69,500. THE UNEMPLOYMENT RATE IN THE CITY OF WATERBURY IN SEPTEMBER 2014 WAS 12.5%. THIS IS HIGHER THAN THE STATE OF CONNECTICUT UNEMPLOYMENT RATE OF 7.8% APPROXIMATELY 35.9% OF THE POPULATION IN WATERBURY SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. THIS IS HIGHER THAN THE STATE OF CONNECTICUT WHERE 23.8% OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. IN ADDITION, 17.1% OF FAMILIES IN WATERBURY HAVE POVERTY STATUS COMPARED TO 6.7% IN CONNECTICUT.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CENTRAL WATERBURY HAS BEEN DESIGNATED A MEDICALLY UNDERSERVED AREA (MUA) AND MEDICALLY UNDERSERVED POPULATION (MUP) BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA). HRSA HAS ALSO DESIGNATED CENTRAL WATERBURY AS A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) FOR PRIMARY MEDICAL CARE, DENTAL CARE AND MENTAL HEALTH.

PART II AND PART VI, LINE 5

SMH'S COMMUNITY BUILDING ACTIVITIES INCLUDE THE FOLLOWING: DISASTER PREPAREDNESS; CONTRIBUTIONS TO THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM; HEALTH CARE ADVOCACY; A VARIETY OF WORKFORCE DEVELOPMENT INITIATIVES INCLUDING LECTURES TO ADDRESS HEALTHCARE WORKFORCE SHORTAGES, RECRUITING MINORITIES AND DIVERSE LANGUAGES, AND SPEAKING TO YOUTH ABOUT CAREERS IN HEALTHCARE; PARTICIPATION IN THE CONNECTICUT HOSPITAL ASSOCIATION'S DIVERSITY COLLABORATIVE; UNITED WAY DAY OF CARING; AND PUBLIC LANDSCAPE ENHANCEMENT AMONG OTHERS. THESE ACTIVITIES PROMOTE HEALTH IN MANY WAYS. THE EFFORTS OF OUR DISASTER PREPAREDNESS COMMITTEE ABOVE AND BEYOND WHAT IS REQUIRED OF THEM HELPS TO PREPARE OUR STAFF AND COORDINATE PLANS WITH OTHER LOCAL AGENCIES (FIRE, POLICE, ETC) IN THE

Part VI Supplemental Information

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EVENT THAT A LOCAL DISASTER WOULD OCCUR. THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM COLLABORATES WITH OTHER LOCAL AGENCIES TO IDENTIFY LEAD HAZARDS IN THE COMMUNITY AND EDUCATE AND TREAT INDIVIDUALS IN AN EFFORT TO PREVENT LEAD HAZARDS THROUGHOUT THE COMMUNITY. A VARIETY OF SMH STAFF ADVOCATE FOR HEALTHCARE REFORM BOTH LOCALLY AND AT THE STATE LEVEL IN AN EFFORT TO IMPROVE ACCESS TO HEALTHCARE AND PUBLIC HEALTH. THE VARIOUS WORKFORCE DEVELOPMENT INITIATIVES ASSURE ACCESS TO HEALTHCARE SERVICES IN OUR COMMUNITY WHILE MAINTAINING HUMAN RESOURCES. BOTH THE UNITED WAY DAY OF CARING AND PUBLIC LANDSCAPE ENHANCEMENT CLEAN UP OUR COMMUNITIES TO PROVIDE A SAFE AND HEALTHY ENVIRONMENT FOR EVERYONE TO WORK, PLAY AND LIVE.

PART II AND PART VI, LINE 5

SAINT MARY'S HOSPITAL OFFERS A VARIETY OF FREE PROGRAMS AND SERVICES THAT ARE SUBSIDIZED BY THE HOSPITAL. FROM MEDICAL AND SURGICAL SERVICES FOR THE UNINSURED AND UNDERINSURED TO HEALTH EDUCATION, SUPPORT GROUPS AND COMMUNITY OUTREACH PROGRAMS, SAINT MARY'S PLAYS AN INTEGRAL ROLE IN THE COMMUNITY WHILE RESPONDING TO THE UNIQUE HEALTHCARE NEEDS OF THE

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RESIDENTS OF GREATER WATERBURY.

EXAMPLES OF SAINT MARY'S MANY COMMUNITY BENEFIT PROGRAMS AND SERVICES PROGRAM, WHICH PROVIDES FREE MAMMOGRAMS FOR WOMEN WHO ARE AGE 40 OR OLDER AND HAVE LITTLE OR NO HEALTH INSURANCE. SAINT MARY'S IS THE ONLY HOSPITAL IN WATERBURY OFFERING THIS PROGRAM, WHICH HAS ASSISTED MORE THAN 2,500 WOMEN SINCE 1995. THE PROGRAM IS OFFERED THROUGH SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER. OTHER EXAMPLES OF SAINT MARY'S COMMUNITY BENEFIT PROGRAMS AND SERVICES INCLUDE SUPPORT GROUPS THAT ARE HOSTED AND SUPPORTED BY THE HOSPITAL FOR PATIENTS SUFFERING FROM ASTHMA AND OUR "BEYOND GRIEF" GROUP PROVIDES BEREAVEMENT SUPPORT FOR ADULTS.

ONE OF THE PROGRAMS THAT HAS HAD AN IMPACT IS CALLED "TEEN GRIEF," WHICH PROVIDES CONFIDENTIAL BEREAVEMENT SUPPORT TO STUDENTS OF LOCAL MIDDLE AND HIGH SCHOOLS. ESTABLISHED BY A PEDIATRIC SOCIAL WORKER FROM SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER IN THE WAKE OF THE TERRORIST ATTACKS OF SEPTEMBER 2001, THIS PROGRAM IS SUPPORTED IN PART BY A GRANT FROM THE J. WALTON BISSELL FOUNDATION. THIS IN SCHOOL PROGRAM ALLOWS TEENS TO COPE

Part VI Supplemental Information

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WITH THEIR GRIEF IN A POSITIVE WAY AND PROVIDES THEM WITH A SAFE PLACE TO EXPRESS THEIR FEELINGS AND LEARN FROM THE EXPERIENCES OF THEIR PEERS. IN ADDITION TO THESE PROGRAMS SAINT MARY'S ALSO HAS SUCCESSFUL PARTNERSHIPS WITH OTHER COMMUNITY ORGANIZATIONS SUCH AS THE GREATER WATERBURY UNITED WAY, WELLPATH BEHAVIORAL HEALTH FOR CHILDREN AND FAMILIES, AND THE MORRIS FOUNDATION, WHICH OFFERS TREATMENT, PREVENTION, EDUCATION, AND RECOVERY SUPPORT FOR INDIVIDUALS WITH SUBSTANCE ABUSE AND BEHAVIORAL HEALTH ISSUES. THE HOSPITAL HAS ALSO FORGED COLLABORATIONS TO BRING WORLD-CLASS HEALTHCARE SERVICES TO THE COMMUNITY THROUGH: - THE HAROLD LEEVER REGIONAL CANCER CENTER, A FREESTANDING 40,000-SQUARE-FOOT FACILITY DEDICATED TO OUTPATIENT CANCER CARE, WHICH IS A JOINT VENTURE PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL; - THE HEART CENTER OF GREATER WATERBURY, WHICH PROVIDES ADVANCED CARDIAC SERVICES, INCLUDING ANGIOPLASTY AND OPEN HEART SURGERY, THROUGH A PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL AND THE UNIVERSITY OF CONNECTICUT HEALTH CENTER/JOHN DEMPSEY HOSPITAL. EXTENDING ITS REACH.

SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER HAS BEEN RECOGNIZED BY

Part VI Supplemental Information

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THE CONNECTICUT LEGISLATURE, STATE CHILD ADVOCACY GROUPS AND THE NATIONAL INITIATIVE FOR CHILD HEALTHCARE QUALITY AS A LEADER AND MODEL PRACTICE IN THE CARE OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS BASED ON ITS "MEDICAL HOME" MODEL OF CARE.

FORMALLY KNOWN AS THE NORTHWEST REGIONAL MEDICAL HOME SUPPORT CENTER, THIS HOSPITAL-BASED PROGRAM PROVIDES ASSISTANCE TO CAREGIVERS OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS AND HAS EXPANDED TO FIVE LOCATIONS: SAINT MARY'S CHILDREN'S HEALTH CENTER, LITCHFIELD COUNTY PEDIATRICS IN TORRINGTON, PEDIATRIC ASSOCIATES OF WESTERN, CT, PEDIATRIC ASSOCIATES OF CT AND THE MEDICAL/PEDIATRICS RESIDENCY TRAINING PROGRAM OPERATED JOINTLY BY SAINT MARY'S HOSPITAL AND YALE-NEW HAVEN HOSPITAL.

THE PROGRAM PROVIDES:

- CARE COORDINATION
- FAMILY SUPPORT
- ADVOCACY
- TITLE V FUNDS

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O BENEFITS COORDINATION

WORKING WITH CAREGIVERS, THE "MEDICAL HOME" PROGRAM HELPS CREATE CUSTOMIZED CARE PLANS AND BRINGS TOGETHER RESOURCES THAT FAMILIES WITH CHILDREN OF SPECIAL NEEDS DEPEND UPON. THE PROGRAM PARTNERS WITH PEDIATRIC CARE PROVIDERS TO MEET THE DIVERSE NEEDS OF CAREGIVERS AND FAMILIES OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS. WORKING THROUGH REHABILITATION AND SCHOOL SERVICES, COMMUNITY AGENCIES AND DEPARTMENT OF SOCIAL SERVICES, THE PROGRAM ESTABLISHES TRANSITION PLANS FOR CHILDREN LEAVING THE PROGRAM AT AGE 21. THE UNITED STATES MATERNAL AND CHILD HEALTH BUREAU DEFINES CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN) AS THOSE WHO HAVE OR ARE AT INCREASED RISK FOR: CHRONIC PHYSICAL, DEVELOPMENTAL, BEHAVIORAL OR EMOTION CONDITIONS (EXPECTED TO LAST AT LEAST A YEAR); AND THOSE WHO REQUIRE HEALTH AND RELATED SERVICES OF A TYPE OR AMOUNT BEYOND THAT REQUIRED BY CHILDREN GENERALLY. EIGHTEEN PERCENT OF CHILDREN IN THE UNITED STATES ARE INCLUDED IN THAT DEFINITION.

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IN ADDITION TO THE COMMUNITY BUILDING ACTIVITIES IDENTIFIED IN RESPONSE TO QUESTION 5 AND THE QUANTIFIED FREE OR DISCOUNTED HEALTH SERVICES IDENTIFIED IN THE REPORTED CHARITY CARE FIGURES, SMH PROVIDES OTHER COMMUNITY BENEFITS. EXAMPLES INCLUDE SCREENINGS, LECTURES, HEALTH FAIRS, SUPPORT GROUPS, CONSULTATIONS, REFERRALS TO OUTSIDE AGENCIES AND OTHERS.

HEALTH PROFESSIONS EDUCATION: SMH IS A TEACHING HOSPITAL AND IS COMMITTED TO PREPARING FUTURE HEALTHCARE PROFESSIONALS. THIS CATEGORY REPRESENTS THE MAJORITY OF SMH'S COMMUNITY BENEFIT ACTIVITIES AND INCLUDES EFFORTS TO GENERATE INTEREST IN HEALTH PROFESSIONS AS WELL AS PROVIDING A CLINICAL SITE FOR MEDICAL STUDENTS, HIGH SCHOOL STUDENTS AND COLLEGES FOR STUDENTS WHO ARE PURSUING DEGREES AS NURSES, PHYSICIAN ASSISTANTS (PA), OCCUPATIONAL, SPEECH AND PHYSICAL THERAPISTS, DENTAL HYGIENISTS, RADIOLOGY TECHNOLOGISTS AND MORE.

SUBSIDIZED SERVICES: SMH PROVIDES HEALTH SERVICES TO PATIENTS WITH NO INSURANCE OR STATE INSURANCE INCLUDING EMERGENCY SERVICES AND BEHAVIORAL

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HEALTH CLINICS.

FINANCIAL AND IN-KIND CONTRIBUTIONS: SMH FINANCIALLY SUPPORTS OTHER COMMUNITY ORGANIZATIONS THROUGH SPONSORSHIPS AND IN-KIND DONATIONS VIA TIME SPENT BY STAFF IN THE COMMUNITY ON LOCAL BOARDS AND VOLUNTEERING TIME FOR LOCAL ORGANIZATIONS.

COMMUNITY BENEFIT OPERATIONS: THE COSTS ASSOCIATED WITH PLANNING AND OPERATING COMMUNITY BENEFIT PROGRAMS ARE IN ITSELF A BENEFIT TO THE COMMUNITY. THIS CATEGORY ALSO INCLUDES COSTS ASSOCIATED WITH CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT AS WELL AS DEVELOPING AN IMPLEMENTATION STRATEGY.

RESEARCH

STATE CANCER REGISTRIES ENABLE PUBLIC HEALTH PROFESSIONALS TO BETTER UNDERSTAND AND ADDRESS CANCER. SUCH INFORMATION IS ESSENTIAL FOR IDENTIFYING WHEN AND WHERE CANCER SCREENING EFFORTS SHOULD BE ENHANCED AND FOR MONITORING THE TREATMENT PROVIDED TO CANCER PATIENTS. IN

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ADDITION, RELIABLE REGISTRY DATA IS FUNDAMENTAL TO A VARIETY OF RESEARCH EFFORTS, INCLUDING THOSE AIMED AT EVALUATING THE EFFECTIVENESS OF CANCER PREVENTION, CONTROL OR TREATMENT PROGRAMS. THE DATA IS REPORTED TO A CENTRAL STATEWIDE REGISTRY FROM VARIOUS MEDICAL FACILITIES INCLUDING HOSPITALS, PHYSICIANS' OFFICES, THERAPEUTIC RADIATION FACILITIES, FREESTANDING SURGICAL CENTERS AND PATHOLOGY LABORATORIES. DURING FISCAL YEAR 2014, THE TOTAL COST ASSOCIATED WITH THE SAINT MARY'S HOSPITAL CANCER REGISTRY WAS $165,239.

PART VI, LINE 6

SAINT MARY'S HOSPITAL PLAYS AN INDISPENSABLE ROLE IN THE HEALTHCARE DELIVERY SYSTEM FOR THE GREATER WATERBURY COMMUNITY AND THE TOWNS OF THE CENTRAL NAUGATUCK VALLEY. FOUNDED IN 1907 BY THE SISTERS OF SAINT JOSEPH OF CHAMBERY, SAINT MARY'S HAS BEEN THE CATHOLIC BEACON OF HEALING AND HOPE IN THE COMMUNITY FOR 100 YEARS. BUILT IN THE HEART OF THE CITY AND WITHIN CLOSE DISTANCE OF ITS ONCE-THRIVING BRASS MILLS SO THAT IT COULD RESPOND READILY TO INJURED WORKERS, THE HOSPITAL HAS EVOLVED INTO A DIVERSE HEALTH SYSTEM THAT TODAY PROVIDES A VARIETY OF HEALTHCARE,

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EDUCATIONAL, FINANCIAL AND OTHER BENEFITS TO THE PEOPLE IT SERVES.

SMH AFFILIATED ORGANIZATIONS SHARE THE GOAL OF PROMOTING HEALTHY LIVING AND DISEASE DETECTION AND PREVENTION THROUGHOUT THE WATERBURY COMMUNITY.

THE HEART CENTER OF GREATER WATERBURY IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HEART CENTER PROMOTES HEALTHY LIVING AND CARDIOVASCULAR DISEASE DETECTION THROUGH SUPPORT GROUPS, SCREENINGS, COMMUNITY HEALTH BOARD INVOLVEMENT, AND COMMUNITY EDUCATION.

THE HAROLD LEEVER CANCER CENTER IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HAROLD LEEVER CANCER CENTER PROMOTES CANCER AWARENESS AND SUPPORT FOR PATIENTS THROUGH SUPPORT GROUPS, SCREENINGS AND COMMUNITY EDUCATION.

SAINT MARY'S HOSPITAL FOUNDATION IS A 501(C)(3) WHOLLY OWNED SUBSIDIARY

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COMPANY OF SAINT MARY'S HEALTH SYSTEM. THE FOUNDATION SUPPORTS THE HOSPITAL'S MISSION BY RAISING MONEY TO BENEFIT A VARIETY OF COMMUNITY NEEDS.

FRANKLIN MEDICAL GROUP IS A CAPTIVE PROFESSIONAL CORPORATION OF MULTI-SPECIALTY PHYSICIANS AFFILIATED WITH SAINT MARY'S HOSPITAL. THE MEDICAL GROUP OPERATES THE CHILDREN'S AND FAMILY HEALTH CENTER, DENTAL CLINIC AND A VARIETY OF CLINICS OFTEN BENEFITING THE UNINSURED POPULATION. IN ADDITION TO PATIENT CARE, PATIENTS BENEFIT FROM A VARIETY OF FREE OR DISCOUNTED SERVICES.

PART VI, LINE 7

CT

PART I, LINE 3C

OUTSTANDING PATIENT ACCOUNT BALANCES LABELED AS SELF PAY, MAY BE SENT TO AN OUTSIDE VENDOR FOR VERIFICATION OF ASSETS. PATIENTS THAT ARE CLASSIFIED AS HAVING NO ASSETS WILL BE WRITTEN OFF TO CHARITY CARE.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☐ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a	X	
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Schedule J (Form 990) 2013

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	CHAD WABLE PRESIDENT AND CEO	(i)	537,551.	180,000.	37,965.	151,575.	35,214.	942,305.	32,316.
		(ii)	0	0	0	0	0	0	0
2	JAMES UBERTI, M.D. DIRECTOR	(i)	0	0	0	0	0	0	0
		(ii)	204,314.	0	774.	6,176.	3,851.	215,115.	0
3	ROBERT RILEY, CFO CFO (FORMER)	(i)	225,836.	0	581.	9,211.	23,636.	259,264.	0
		(ii)	0	0	0	0	0	0	0
4	SANDRA ROOSA VP PATIENT SVC	(i)	0	0	221,872.	17,750.	19,007.	258,629.	0
		(ii)	0	0	0	0	0	0	0
5	MICHAEL NOVAK VP OPERATIONS	(i)	231,837.	57,061.	414.	11,700.	27,846.	328,858.	0
		(ii)	0	0	0	0	0	0	0
6	CAROLYN ORRELL CIO (FORMER)	(i)	17,113.	10,000.	188,305.	0	5,125.	220,543.	0
		(ii)	0	0	0	0	0	0	0
7	M. CLARK KEARNEY VP HUMAN RESOURCES	(i)	199,507.	48,644.	1,218.	10,951.	25,711.	286,031.	0
		(ii)	0	0	0	0	0	0	0
8	JOSEPH CONNOLLY CHIEF MARKETING OFFICER	(i)	160,067.	24,959.	331.	9,403.	27,667.	222,427.	0
		(ii)	0	0	0	0	0	0	0
9	STEPHEN SCHNEIDER, MD CMO	(i)	0	0	0	0	0	0	0
		(ii)	351,095.	87,500.	1,188.	11,700.	43,948.	495,431.	0
10	GREG BULLER, MD CHAIRMAN, DEPT. OF MEDICINE	(i)	254,786.	0	774.	15,300.	3,465.	274,325.	0
		(ii)	0	0	0	0	0	0	0
11	ELIZABETH BOZZUTO VP SURGICAL SERVICES	(i)	231,261.	57,288.	1,553.	26,134.	21,656.	337,892.	0
		(ii)	0	0	0	0	0	0	
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Schedule J (Form 990) 2013

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Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J - PART I, LINE 4A

SANDRA ROOSA'S EMPLOYMENT CONTRACT INCLUDED A PROVISION FOR SALARY CONTINUATION. FOR PURPOSES OF SCHEDULE H, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III).

CAROLYN ORRELL RECEIVED A ONE YEAR SEVERANCE PACKAGE. THE AMOUNT IS INCLUDED IN COLUMN B(III).

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SCHEDULE J - PART I - LINE 4B

CHAD WABLE PARTICIPATES IN A 457(F) DEFERRED COMPENSATION PLAN. THE CONTRIBUTION FROM 2008 BECAME VESTED DURING FISCAL YEAR 2014. FOR PURPOSES OF SCHEDULE J, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III). IT IS ALSO LISTED IN COLUMN (F) AS IT WAS PREVIOUSLY REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990.

SCHEDULE J - PART I - QUESTION 6A

EACH SENIOR LEADER IS PROVIDED A BONUS BASED ON NET EARNINGS AND OTHER CORPORATE GOALS. THE BONUS IS CONTINGENT ON CORPORATE GOALS AND OBJECTIVES EACH YEAR. DURING FY2014, THERE WERE 5 OBJECTIVES: PEOPLE,

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SERVICE, QUALITY, FINANCE, AND GROWTH. THE BONUS IS COMPUTED ON A

PERCENTAGE ALLOCATION FOR THE WEIGHT OF EACH OBJECTIVE WHICH IS DIFFERENT

FOR EACH SENIOR LEADER BASED ON THEIR JOB FUNCTION.

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SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Part I **Excess Benefit Transactions** (section 501(c)(3) and section 501(c)(4) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

	(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total						▶ $							

Part III **Grants or Assistance Benefiting Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part IV Business Transactions Involving Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)	NAUGATUCK VALLEY WOMENS HEALTH	DIRECTOR - M. ALBINI	346,000.	SEE PART V FOR DESCRIPTIO		X
(2)	WEBSTER FINANCIAL SERVICES	DIRECTOR - J. SMITH	505,110.	SEE PART V FOR DESCRIPTIO		X
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information
Provide additional information for responses to questions on Schedule L (see instructions).

PART IV

DR. MARK ALBINI IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HOSPITAL, INC. DURING THE YEAR ENDING SEPTEMBER 30, 2014, THE HOSPITAL PAID DR. ALBINI'S PRACTICE, NAUGATUCK VALLEY WOMEN'S HEALTH, PC, $297,000 IN FEES FOR SERVICE. IN ADDITION, DR. ALBINI WAS PAID $49,000 BY SAINT MARY'S HOSPITAL FOR SERVICES PERFORMED DIRECTLY BY HIM FOR THE HOSPITAL.

MR. JAMES C. SMITH IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HEALTH SYSTEM, WHICH IS THE PARENT HOLDING COMPANY OF SAINT MARY'S HOSPITAL, INC. MR. SMITH IS ALSO THE CHAIRMAN OF WEBSTER BANK. THE HOSPITAL HAS A LINE OF CREDIT THROUGH WEBSTER BANK, THE BALANCE OF THE LINE OF CREDIT AT THE END OF THE REPORTING PERIOD WAS $0. DURING THE YEAR ENDED SEPTEMBER 30, 2014, THE HOSPITAL INCURRED $3,025 IN FEES ON THE LINE OF CREDIT AND PAID $116,016 IN BANKING FEES.

THE HOSPITAL ALSO PAYS WEBSTER FINANCIAL ADVISORS, A COMPANY RELATED TO THE WEBSTER BANK, TO ADMINISTER ITS PENSION PLAN AND OTHER INVESTMENT MANAGEMENT SERVICES. DURING THE YEAR ENDED SEPTEMBER 30, 2014, SAINT

Part IV **Business Transactions Involving Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V **Supplemental Information**
Provide additional information for responses to questions on Schedule L (see instructions).

MARY'S HOSPITAL, INC. AND ITS AFFILIATES PAID $159,316 FOR INVESTMENT MANAGEMENT SERVICES AND $226,753 FOR AMINISTRATION OF THE HOSPITAL'S RETIREMENT PLAN ASSETS.

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

990 PART III - LINE 4A

INPATIENT SERVICES SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014, WITH AN AVERAGE LENGTH OF STAY OF 4.23 DAYS. SAINT MARY'S THREE LARGEST PROGRAMS ARE SURGERY, CARDIOLOGY AND MEDICINE.

IN 2014, 867 PATIENTS CHOSE TO HAVE GENERAL SURGERY AT SAINT MARY'S, STAYING AT THE HOSPITAL FOR A TOTAL OF 4,924 DAYS AND GENERATED $14 MILLION IN REVENUE; 1,354 PATIENTS CHOSE SAINT MARY'S FOR CARDIAC CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 5,854 DAYS AND GENERATING $19 MILLION IN REVENUE; AND 4,004 PATIENTS RECEIVED INPATIENT MEDICAL CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 19,158 DAYS, AND GENERATING $39 MILLION IN REVENUE.

AS THE HOSPITAL CONTINUES TO DISTINGUISH ITSELF AS A LEADING PROVIDER OF HEALTHCARE SERVICES IN THE REGION, IT HAS GARNERED RECOGNITION FROM STATE AND NATIONAL ORGANIZATIONS FOR PROVIDING OUTSTANDING PATIENT CARE.

SAINT MARY'S HOSPITAL IS RANKED AS THE TOP-PERFORMING HOSPITAL IN CONNECTICUT FOR DELIVERING PERCUTANEOUS CORONARY INTERVENTION (PCI), A LIFE-SAVING PROCEDURE THAT OPENS THE BLOCKED ARTERIES OF HEART ATTACK PATIENTS. THE NATIONAL STANDARD STATES THAT PATIENTS SHOULD RECEIVE THIS PROCEDURE WITHIN 90 MINUTES OF ARRIVAL AT THE HOSPITAL. ACCORDING TO THE

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FEDERAL CENTERS FOR MEDICARE AND MEDICAID (CMS), 100 PERCENT OF PATIENTS WHO REQUIRE ANGIOPLASTY RECEIVE IT AT SAINT MARY'S WITHIN 90 MINUTES OF ARRIVAL. THIS RANKS SAINT MARY'S AS THE NUMBER ONE PERFORMING HOSPITAL IN CONNECTICUT, AND SIGNIFICANTLY AHEAD OF THE NATIONAL AVERAGE, WHICH IS 79 PERCENT OF PATIENTS BEING TREATED WITHIN 90 MINUTES.

IN ADDITION, SAINT MARY'S IS THE FIRST HOSPITAL IN CONNECTICUT TO RECEIVE A GOLD AWARD UNDER THE AMERICAN HEART ASSOCIATION'S GET WITH THE GUIDELINES PROGRAM FOR ITS TREATMENT OF PATIENTS WITH CORONARY ARTERY DISEASE. IT IS ALSO THE FIRST HOSPITAL IN THE STATE TO RECEIVE A GOLD AWARD FOR ITS TREATMENT OF PATIENTS WITH HEART FAILURE. AS OF FISCAL YEAR 2014, SAINT MARY'S HAS RECEIVED SIX GOLD AWARDS FOR CARDIAC CARE. THESE ACCOMPLISHMENTS ARE INDICATIVE OF THE EXTRAORDINARY CROSS-DISCIPLINE COLLABORATION AND OVERALL COMMITMENT TO CLINICAL EXCELLENCE SHARED BY THE SAINT MARY'S TEAM.

IN THE 2014 FISCAL YEAR, SAINT MARY'S ALSO ACHIEVED THE HIGHEST SCORES IN THEIR ESPECTIVE SIZE/GEOGRAPHIC GROUP EARNING THEM A SPOT ON THE CLEVERLY ASSOCIATES COMMUNITY VALUE 100 LIST FOR BEING A TOP VALUE HOSPITAL. IN ADDITION IN 2014, SAINT MARY'S WAS ONE OF ONLY 712 HOSPITALS IN THE UNITED STATES TO ACHIEVE THE TOP PERFORMER DISTINCTION TWO YEARS IN A ROW FROM THE JOINT COMMISSION.

IN ADDITION, SAINT MARY'S IS A LEADER IN SURGICAL SERVICES. OUR PHYSICIANS PROVIDE BOTH IN-PATIENT AND OUT-PATIENT SURGERY IN THE AREAS

OF GI, ONCOLOGY, THORACIC, VASCULAR, LAPAROSCOPY, TRAUMA, GYNECOLOGY, UROLOGY, NEUROSURGERY, ORTHOPEDICS, CARDIOTHORACIC, PLASTIC, BARIATRIC AND ENDOCRINE SURGERY AT SAINT MARY'S HOSPITAL.

OUR EXPERIENCED SURGEONS PERFORM ADVANCED ROBOTIC-ASSISTED PROCEDURES UTILIZING TWO DAVINCI® ROBOTIC SURGICAL SYSTEMS. THIS INNOVATIVE TECHNOLOGY IS BECOMING THE STANDARD OF CARE FOR MANY COMPLEX SURGICAL PROCEDURES WITH APPLICATIONS FOR GYNECOLOGIC, UROLOGIC, THORACIC, CARDIAC AND GENERAL SURGERY. AS THE LEADING PROVIDER OF SURGICAL SERVICES IN THE REGION, SAINT MARY'S IS COMMITTED TO PROVIDING THE HIGHEST QUALITY AND SUPERIOR SERVICE FOR OUR PATIENTS. DURING FISCAL YEAR 2014, SAINT MARY'S PERFORMED 653 SURGERIES USING THE DAVINCI® ROBOTIC SURGICAL SYSTEMS.

IN ADDITION, THE HOSPITAL OFFERS A COMPREHENSIVE SIX- YEAR TRAINING PROGRAM IN GENERAL SURGERY. SAINT MARY'S HOSPITAL IS COMMUNITY BASED AND BOASTS A CLOSE AFFILIATION TO YALE UNIVERSITY IN NEARBY NEW HAVEN, CONNECTICUT, AND THE UNIVERSITY OF CONNECTICUT IN FARMINGTON, CONNECTICUT. HISTORICALLY, NEARLY ONE HALF OF THE RESIDENTS COMPLETING THIS PROGRAM HAVE PURSUED FURTHER TRAINING IN CARDIOTHORACIC, COLON AND RECTAL, PLASTIC AND RECONSTRUCTIVE, SURGICAL ONCOLOGY, OR VASCULAR SURGERY.

990 PART III - LINE 4B

SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. THE HEALTH SYSTEM'S TWO LARGEST PROGRAMS ARE ITS

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Name of the organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

EMERGENCY DEPARTMENT, WHICH PROVIDED TREATMENT TO 62,335 PATIENTS IN 2014, GENERATING $26 MILLION IN REVENUE, AND AMBULATORY SURGERY. IN 2014, 14,313 PATIENTS CHOSE TO HAVE OUTPATIENT SURGERY AT SAINT MARY'S, GENERATING $47 MILLION IN REVENUE.

OUTPATIENT SERVICES INCLUDE BUT ARE NOT LIMITED TO: MEDICAL IMAGING, BLOOD DRAW AND LAB SERVICES, CARDIAC AND PULMONARY REHABILITATION CLASSES, NUTRITIONAL COUNSELING AND EXPECTANT PARENT CLASSES. SAINT MARY'S SATELLITE FACILITIES INCLUDE HEALTH AND WELLNESS CENTERS PROVIDING URGENT CARE, BLOOD DRAW STATIONS AND X-RAY SERVICES IN NAUGATUCK AND WOLCOTT; OUTPATIENT REHABILITATION THERAPY OFFICES IN WATERBURY, WOLCOTT AND NAUGATUCK; OUTPATIENT SLEEP DISORDERS CENTERS IN WATERBURY AND WOLCOTT; THE BREAST & ONCOLOGY CENTERS IN SOUTHBURY AND PROSPECT, AND OCCUPATIONAL THERAPY IN WATERBURY.

SAINT MARY'S HAS BEEN RECOGNIZED AT THE STATE AND NATIONAL LEVELS AS A DISTINGUISHED PROVIDER OF OUTPATIENT SERVICES.

ONE ADDITION TO THE OUTPATIENT SERVICES INCLUDED THE LIONS LOW VISION CENTER WHICH IS ONE OF ONLY FIVE CENTERS IN CONNECTICUT AND THE ONLY CETNER OF ITS KIND IN GREATER WATERBURY. SPECIALISTS COLLABORATE WITH PATIENTS' EYE CARE PROFESSIONLS AND HELP PATIENTS MAKE THE MOST OF THEIR AVAILABLE VISION WITH EXERCISES, COMPENSATORY STRATEGIES, AND TRAINING WITH LOW VISION AIDES.

SAINT MARY'S IS AMONG THE LARGEST AND BUSIEST EMERGENCY DEPARTMENTS IN THE STATE OF CONNECTICUT. IN FACT, WITH APPROXIMATELY 67,000 EMERGENCY VISITS PER YEAR, WE RANK AS THE 9TH BUSIEST IN THE STATE.

THE SAINT MARY'S EMERGENCY DEPARTMENTS IS A CERTIFIED LEVEL 2 TRAUMA CENTER, AND ALL PHYSICIANS ARE BOARD CERTIFIED IN EMERGENCY MEDICINE. THE EMERGENCY DEPARTMENT PLAYS A CRITICAL ROLE IN HELPING SAINT MARY'S ACHIEVE ITS EXTRAORDINARY PERFORMANCE WITH DOOR-TO-BALLOON TIME, A MEASURE OF THE TIME IT TAKES A HEART ATTACK VICTIM TO HAVE HIS OR HER BLOCKED ARTERIES OPENED. SAINT MARY'S MEDIAN DOOR-TO-BALLOON TIME IS 60 MINUTES. SAINT MARY'S DOOR-TO-BALLOON TIME IS 30 MINUTES FASTER THAN NATIONAL GUIDELINES SET BY THE AMERICAN COLLEGE OF CARDIOLOGY FOR OPENING BLOCKED ARTERIES.

THE DEPARTMENT ALSO PROVIDES AMBULATORY CARE SERVICES, WHICH ARE DESIGNED TO ACCOMMODATE NON-EMERGENT, LOWER ACUITY NEEDS. THIS UNIT CONTAINS A PEDIATRIC CENTER, WHICH IS STAFFED BY PEDIATRICIANS EACH AFTERNOON.

FINALLY, THE EMERGENCY DEPARTMENT CONTAINS A DEDICATED BEHAVIORAL HEALTH AREA, SUPPORTED BY A PSYCHIATRIST, SOCIAL WORKER AND SPECIALIZED NURSES. THIS UNIT PROVIDES A MUCH NEEDED RESOURCE FOR SERVING OUR PATIENT POPULATION, AND HAS SEEN CONTINUED GROWTH AND INCREASE IN DEMAND.

SAINT MARY'S CANCER PROGRAM WAS AWARDED A THREE-YEAR ACCREDITATION FROM THE AMERICAN COLLEGE OF SURGEONS' COMMISSION ON CANCER WITH COMMENDATION.

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ONLY 40 PERCENT OF ALL U.S. HOSPITALS SURVEYED BY THE COMMISSION ACHIEVE THIS LEVEL OF RECOGNITION. ACS ACCREDITATION ENSURES THAT PATIENTS WHO CHOOSE SAINT MARY'S FOR CANCER CARE HAVE ACCESS TO A COMPLETE RANGE OF STATE-OF-THE-ART SERVICES AND EQUIPMENT, A TEAM THAT COORDINATES THE BEST AVAILABLE TREATMENT OPTIONS, AND ACCESS TO CLINICAL TRIALS AND NEW TREATMENT OPTIONS, AS WELL AS EARLY DETECTION PROGRAMS, EDUCATION AND SUPPORT SERVICES.

SAINT MARY'S WOUND HEALING CENTER IS STAFFED BY A SPECIALIZED TEAM OF PHYSICIANS, SURGEONS, NURSES AND TECHNICIANS, WHO COLLABORATE TO PRODUCE THE BEST POSSIBLE OUTCOMES. ON AVERAGE, 92.7 PERCENT OF PATIENTS WHO COME TO THE CENTER WITH CHRONIC WOUNDS THAT HAVE RESISTED TRADITIONAL TREATMENT ACHIEVE SUCCESSFUL RESULTS WITHIN 14 WEEKS. SPECIALIZED WOUND CARE ALSO HELPS PATIENTS WITH DIABETIC ULCERS, PRESSURE ULCERS, INFECTIONS AND COMPROMISED SKIN GRAFTS. IN ADDITION THE CENTER OFFERS HYPERBARIC OXYGEN THERAPY, WHICH IS PARTICULARLY EFFECTIVE FOR PATIENTS WHO SUFFER FROM RADIATION DAMAGE OR FACE THE POSSIBILITY OF AMPUTATION.

FORM 990, PART III
BUILDING UPON A LEGACY OF CARING THE MISSION OF SAINT MARY'S HOSPITAL IS TO PROVIDE EXCELLENT HEALTHCARE SERVICES IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

IT IS THE HOSPITAL'S VISION TO BECOME AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS CREATING EXCEPTIONAL VALUE FOR THOSE WE SERVE THROUGH TRUSTED PARTNERSHIPS THAT EMPOWER AND TRANSFORM LIVES. THE HOSPITAL'S STAFF,

MEDICAL STAFF, BOARD OF DIRECTORS, FOUNDATION, AUXILIARY, AND VOLUNTEERS ARE ALSO UNITED BY THESE VALUES:

-INTEGRITY - COMMITMENT TO DOING WHAT IS RIGHT

- CARING - COMPASSIONATE APPROACH TO ADDRESSING THE HEALTHCARE NEEDS OF ALL PEOPLE

- ACCOUNTABILITY - PERSONAL RESPONSIBILITY FOR THE PERFORMANCE OF SAINT MARY'S HEALTH SYSTEM

- RESPECT - RESPECT FOR THE DIGNITY, WORTH, AND RIGHTS OF OTHERS

- EXCELLENCE - WORKING TOGETHER IN PURSUIT OF SUPERIOR CLINICAL QUALITY AND SERVICE TO OTHERS

990 PART VI SECTION A LINE 7A

SAINT MARY'S HEALTH SYSTEM, INC. IS THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC. AND APPOINTS THE BOARD OF DIRECTORS.

ARE THE DECISIONS OF THE GOVERNING BODY SUBJECT TO APPROVAL

990 PART VI SECTION A LINE 7B

PURSUANT TO THE PROVISIONS OF SECTION 33-1080(B) OF THE CONNECTICUT REVISED NON-STOCK CORPORATION ACT AND THE AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE CORPORATION, THERE SHALL BE RESERVED TO THE ARCHBISHOP OF THE HARTFORD ROMAN CATHOLIC ARCHDIOCESE OF HARTFORD (UNLESS SPECIFICALLY DELEGATED BY HIM) THE FOLLOWING RIGHTS AND POWERS: (A)TO APPROVE THE MISSION OR PURPOSE AND THE PHILOSOPHY OF THE CORPORATION AND OF ANY SAINT MARY'S SUBSIDIARIES. (B)TO APPROVE THE ACQUISITION, ALIENATION OR CONVEYANCE OF THE REAL PROPERTY OF THE CORPORATION THAT IS VALUED AT AN AMOUNT GREATER THAN THAT ESTABLISHED BY

THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW OR TO PLACE A MORTGAGE ON SUCH PROPERTY OR TO BORROW FUNDS IN AMOUNTS GREATER THAN THOSE ESTABLISHED BY THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW, WHETHER IN A SINGLE TRANSACTION OR A SERIES OF RELATED TRANSACTIONS. (C)TO APPROVE THE DISPOSAL OF ALL OR SUBSTANTIALLY ALL OF THE PHYSICAL ASSETS OF THE CORPORATION AND TO APPROVE THE MERGER OR CONSOLIDATION OF THE CORPORATION. (D)TO APPROVE THE AMENDMENT OF THE CERTIFICATE OF INCORPORATION OR THE BYLAWS OF THE CORPORATION.

PART VI, SECTION B, LINE 11A

THE FORM 990 WAS DISTRIBUTED TO BOARD MEMBERS AND THE ORGANIZATION'S FINANCE COMMITEE FOR THEIR REVIEW PRIOR TO FILING TO ENSURE ACCURACY AND COMPLETENESS. A COMPLETE COPY OF THE ORGANIZATION'S FINAL FORM 990, INCLUDING ALL REQUIRED SCHEDULES, AS ULTIMATELY FILED WITH THE IRS, WAS PROVIDED TO EACH MEMBER OF THE BOARD BEFORE ITS FILING WITH THE IRS.

990 PART VI - SECTION B - LINE 12C

ANNUALLY, EACH DIRECTOR, OFFICER, AND BOARD COMMITTEE MEMBER OF SMHS AND ANY OF ITS AFFILIATES, AS APPROPRIATE, WILL SIGN A STATEMENT WHICH AFFIRMS THAT THE PERSON:

1) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY;

2) HAS READ AND UNDERSTANDS THE POLICY; AND

3) HAS AGREED TO COMPLY WITH THE POLICY.

THE STATEMENTS WILL BE DISTRIBUTED ANNUALLY BY THE COMPLIANCE OFFICER AND RETURNED TO THE CEO OR DELEGATED PERSON, WHERE THEY WILL BE RECORDED, REVIEWED, SUMMARIZED AND PRESENTED TO THE CHAIRPERSON OF THE BOARD, AS WELL AS TO THE AUDIT AND GOVERNANCE COMMITTEES, WHERE THEY EXISTS. CONFLICT OF INTEREST STATEMENTS WILL BE MAINTAINED FOR A MINIMUM OF SEVEN YEARS BY THE COMPLIANCE OFFICER.

CONFLICT OF INTEREST FORMS PROVIDED BY OFFICERS, DIRECTORS AND BOARD COMMITTEE MEMBERS WILL BE FORWARDED TO THE COMPLIANCE OFFICER, ALONG WITH A STATEMENT OF IMPACT AS TO THE EFFECT OF THE CONFLICT OF INTEREST ON THE BUSINESS AND ANY ACTION TAKEN TO MINIMIZE THE EFFECT. THEY WILL BE MAINTAINED BY THE COMPLIANCE OFFICER FOR A MINIMUM OF SEVEN YEARS.

990 PART VI - SECTION B - LINES 15A & 15B

THE PROCESS FOR DETERMINING THE COMPENSATION OF THE HOSPITAL'S TOP MANAGEMENT OFFICIALS, INCLUDING THE CEO, ALL OFFICERS, AND KEY EMPLOYEES, MEET THE THREE REQUIREMENTS OF THE REBUTTABLE PRESUMPTION. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY THE ORGANIZATION'S EXECUTIVE COMPENSATION COMMITTEE. THE COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS FOR THE PURPOSE OF ASSISTING THE BOARD TO FULFILL ITS RESPONSIBILY TO THE HOSPITAL AND THE COMMUNITY TO ENSURE THE COMPENSATION IS IN ACCORDANCE WITH THE HOSPITAL'S POLICIES. THE COMMITTEE IS COMPRISED OF SIX DIRECTORS WHO ARE INDEPENDENT OF MANAGEMENT AND THE HOSPITAL AND FREE OF ANY CONFLICTS OF INTEREST THAT WOULD INTERFERE WITH THEIR EXERCISE OF INDEPENDENT JUDGEMENT. PRIOR TO MAKING ANY COMPENSATION DECISIONS, THE EXECUTIVE COMPENSATION COMMITTEE OBTAINED AND

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Name of the organization: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

RELIED UPON APPROPRIATE DATA AS TO COMPARABILITY. THE COMMITTEE CONTRACTS AN INDEPENDENT COMPENSATION CONSULTANT AND UTILIZES LOCAL AND NATIONAL COMPENSATION SURVERY'S TO SET COMPENSATION LEVELS. FINALLY, THE EXECUTIVE COMPENSATION COMMITTEE ADEQUATELY AND TIMELY DOCUMENTED THE BASIS FOR SETTING COMPENSATION CONCURRENTLY WITH THE MAKING OF THE DETERMINATION.

PART VI, SECTION C, QUESTION 19

COPIES OF THE GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

PART XI, LINE 9

TRANSFERS TO AFFILIATES	($14,778,000)
MINIMUM PENSIONS LIAB CHANGE	($13,377,000)
CHANGE IN FOUNDATION INTEREST	$ 351,580
NET ADDITIONS TO ASSETS HELD IN TRUST	$ 426,000
OTHER	($ 47,173)
TOTAL	($27,424,593)

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
SODEXHO INC. & AFFILIATES PO BOX 905374 CHARLOTTE, NC 28290	HOSPITAL MGMT SVCS	3,285,079.

Public Disclosure Copy

Name of the organization: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

ATTACHMENT 1 (CONT'D)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MIDDLE CT EMERGENCY PHYSICIANS 1000 RIVER ROAD, SUITE 100 CONSHOHOCKEN, PA 19428	EMERGENCY ROOM SVCS	2,825,989.
PRECYSE SOLUTIONS LLC PO BOX 11407 BIRMINGHAM, AL 35246	CONTRACT LABOR SVCS	3,886,995.
FINANCIAL HEALTH STRATEGIES 704 QUINCE ROAD, SUITE 300 GAITHERSBURG, MD 20878	CONTRACT LABOR SVCS	1,449,472.
ANTHELIO ONE FINANCIAL CENTER BOSTON, MA 02111	HOSP MGMT/IT HOSTING	2,599,856.

ATTACHMENT 2

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
MRI PARTNERSHIP INCOME	-55,484.			-55,484.
DIAGNOSTIC IMAGING CENTER INCOME	646,709.			646,709.
PREMIER INCOME	667,720.		-4,499.	672,219.
HLRCC JV NET INCOME	-423,587.			-423,587.
DIVIDEND & INTEREST REVENUE	2,931,875.			2,931,875.
TOTALS	3,767,233.		-4,499.	3,771,732.

ATTACHMENT 3

Public Disclosure Copy

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

ATTACHMENT 3 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION		BEGINNING BOOK VALUE	ENDING BOOK VALUE	COST OR FMV
MARKETABLE SECURITIES		18,505,914.	20,802,742.	FMV
	TOTALS	18,505,914.	20,802,742.	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990. ▶ See separate instructions.

▶ Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

ST. MARY'S HOSPITAL, INC.

Employer identification number

06-0646844

Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ST. MARY'S INDEMNITY COMPANY, LLC 06-0646844 126 COLLEGE STREET BURLINGTON, VT 05401	INSURANCE	VT	2,523,000.	46,719,000.	ST MARY HOSP
(2) ST. MARY'S PHYSICIAN PARTNERS, LLC 46-5760769 56 FRANKLIN STREET WATERBURY, CT 06706	ACCOUNT. CARE	CT	0	0	ST MARY HOSP
(3)					
(4)					
(5)					
(6)					

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1) ST. MARY'S HEALTH SYSTEM, INC. 22-2528399 56 FRANKLIN STREET WATERBURY, CT 06703	HOLDING CO.	CT	501(C)(3)	11B	N/A		X
(2) SAINT MARY'S FOUNDATION 22-2528400 56 FRANKLIN STREET WATERBURY, CT 06703	FUNDRAISING	CT	501(C)(3)	7	ST MARY HOSP	X	
(3) HAROLD LEEVER REGIONAL CANCER CENTER 06-1548409 1075 CHASE PARKWAY WATERBURY, CT 06708	TREATMENT CTR	CT	501(C)(3)	3	ST MARY HOSP	X	
(4) HEART CENTER OF GREATER WATERBURY, INC. 83-0416893 P.O. BOX 2153 WATERBURY, CT 06722	MANAGEMENT	CT	501(C)(3)	11A	ST MARY HOSP	X	
(5)							
(6)							
(7)							

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) DIAGNOSTIC IMAGING OF SOUTHBUR 385 MAIN STREET SOUTH	IMAGING CENTER	CT	N/A	RELATED	735,013.	1,412,020.		X	0			60.0000
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) FRANKLIN MEDICAL GROUP, PC 06-1470493 56 FRANKLIN STREET WATERBURY, CT 06706	PHYSICIAN OFF	CT	N/A	C CORP	-12,810,000.	5,492,000.	100.0000	X	
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

		Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a X	
b	Gift, grant, or capital contribution to related organization(s)	1b X	
c	Gift, grant, or capital contribution from related organization(s)	1c X	
d	Loans or loan guarantees to or for related organization(s)	1d	X
e	Loans or loan guarantees by related organization(s)	1e	X
f	Dividends from related organization(s)	1f	X
g	Sale of assets to related organization(s)	1g	X
h	Purchase of assets from related organization(s)	1h	X
i	Exchange of assets with related organization(s)	1i	X
j	Lease of facilities, equipment, or other assets to related organization(s)	1j	X
k	Lease of facilities, equipment, or other assets from related organization(s)	1k	X
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l X	
m	Performance of services or membership or fundraising solicitations by related organization(s)	1m X	
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n X	
o	Sharing of paid employees with related organization(s)	1o X	
p	Reimbursement paid to related organization(s) for expenses	1p	X
q	Reimbursement paid by related organization(s) for expenses	1q X	
r	Other transfer of cash or property to related organization(s)	1r	X
s	Other transfer of cash or property from related organization(s)	1s X	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	FRANKLIN MEDICAL GROUP, PC	B	14,281,747.	FMV
(2)	FRANKLIN MEDICAL GROUP, PC	M	2,961,355.	FMV
(3)	DIAGNOSTIC IMAGING OF SOUTHBURY, LLC	S	546,000.	FMV
(4)	ST. MARY'S HOSPITAL FOUNDATION, INC.	C	75,420.	FMV
(5)	FRANKLIN MEDICAL GROUP, PC	O	495,431.	FMV
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

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Part VII **Supplemental Information**
Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

KPMG

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

December 22, 2014

SAINT MARY'S HOSPITAL, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets		2014	2013
Current assets:			
Cash and cash equivalents	$	25,797	28,902
Short-term investments		17	29
Current portion of assets whose use is limited		5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013		30,196	30,730
Other current assets		6,612	4,357
Total current assets		68,570	72,057
Marketable securities		20,803	18,506
Assets whose use is limited:			
By donor and held in trust by others		15,696	15,258
For estimated self-insurance liability		41,038	31,394
By bond indenture		4,321	4,324
Net interest in Foundation		5,182	4,874
Other		6	6
Total assets whose use is limited		66,243	55,856
Less current portion of assets whose use is limited		5,948	8,039
Noncurrent assets whose use is limited		60,295	47,817
Property and equipment, net		62,371	63,874
Other assets:			
Investments in joint venture arrangements		10,024	10,697
Deferred financing costs, net		103	128
Total other assets		10,127	10,825
Total assets	$	222,166	213,079
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term obligations	$	2,509	2,490
Accounts payable		17,252	20,899
Salaries, wages, and payroll withholdings		5,643	4,734
Due to third-party payors, net		783	6,035
Accrued expenses and other current liabilities		14,308	16,486
Total current liabilities		40,495	50,644
Long-term liabilities:			
Long-term obligations, net of current portion		17,891	20,374
Estimated self-insurance liability		31,814	21,908
Pension and deferred compensation		72,182	58,823
Other long-term liabilities		9,523	10,172
Total long-term liabilities		131,410	111,277
Net assets:			
Unrestricted Hospital		30,795	32,332
Noncontrolling interest in subsidiaries		370	302
Total unrestricted		31,165	32,634
Temporarily restricted		2,415	2,269
Permanently restricted		16,681	16,255
Total net assets		50,261	51,158
Total liabilities and net assets	$	222,166	213,079

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowances	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	9,776	6,871
Total revenues	277,863	262,892
Expenses:		
Salaries and wages	113,207	108,642
Employee benefits	28,620	31,294
Supplies and other expenses	115,262	103,072
Depreciation and amortization	10,455	9,977
Interest	1,438	1,594
Total expenses	268,982	254,579
Operating income	8,881	8,313
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Change in net assets of Foundation	281	437
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,965	2,195
Excess revenues over expenses	12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	$ (1,469)	31,754

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,469)	31,754
Temporarily restricted net assets:		
Change in net assets of Foundation	146	(100)
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(897)	32,426
Net assets – beginning of year	51,158	18,732
Net assets – end of year	$ 50,261	51,158

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (897)	32,426
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,480	10,003
Net loss on disposal of assets	46	230
Change in unrealized losses (gains) on investments	527	(401)
Change in net interest in Foundation	(308)	(379)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	534	3,287
Other current assets	(2,255)	125
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,702)	1,522
Estimated self-insurance liability	9,906	2,846
Pension, deferred compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,350	24,062
Cash flows from investing activities:		
Purchases of property and equipment	(7,212)	(15,479)
Distributions from joint ventures	546	420
Investments in joint venture arrangements	316	272
Change in other assets whose use is limited	(6,258)	106
Change in assets held in trust by others	426	949
Net decrease in investments	(2,812)	(2,052)
Net cash used in investing activities	(14,994)	(15,784)
Cash flows from financing activities:		
Change in assets whose use is limited by bond indenture	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net (decrease) increase in cash and cash equivalents	(3,105)	6,378
Cash and cash equivalents – beginning of year	28,902	22,524
Cash and cash equivalents – end of year	$ 25,797	28,902
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,558
Supplemental disclosure of noncash item:		
Assets acquired under capital lease	$ —	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

(Continued)

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments in Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Interest in Foundation

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

(k) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

(l) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

(m) Income Taxes

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

(n) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(o) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(p) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(q) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

	2014	2013
Gross revenue from patient services	$ 733,919	670,163
Contractual and other allowances	(454,430)	(401,170)
Charity care	(328)	(94)
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	$ 268,087	256,021

(Continued)

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$ 271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$ 257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 18,630	18,630	—	—	—	—
Corporate bonds	11,820	11,807	1,062	(18)	4,559	(162)
U.S. government and agency obligations	14,023	13,990	2,926	(16)	1,686	(34)
Mutual funds	25,357	21,016	608	(9)	—	—
Equities	1,145	1,173	605	(62)	—	—
	$ 70,975	66,616	5,201	(105)	6,245	(196)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,671	2,671	—	—	—	—
Corporate bonds	15,083	15,885	4,668	(274)	734	(53)
U.S. government and agency obligations	13,769	12,984	3,731	(42)	304	(5)
Mutual funds	27,155	21,326	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 63,311	56,918	9,105	(332)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 17,838	—	—	17,838
Domestic corporate bonds	—	9,838	—	9,838
U.S. government and agency obligations	—	12,347	—	12,347
Equity mutual funds	14,925	—	—	14,925
Equity funds	331	—	—	331
Total	33,094	22,185	—	55,279
Assets held in trust by others: Perpetual trust	—	—	15,696	15,696
Total	$ 33,094	22,185	15,696	70,975

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,307	—	—	2,307
Domestic corporate bonds	—	12,723	—	12,723
U.S. government and agency obligations	—	11,518	—	11,518
Equity mutual funds	17,017	—	—	17,017
Equity funds	4,488	—	—	4,488
Total	23,812	24,241	—	48,053
Assets held in trust by others: Perpetual trust	—	—	15,258	15,258
Total	$ 23,812	24,241	15,258	63,311

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

	2014	2013
Perpetual trust:		
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(Continued)

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,911	7,328
Buildings and building improvements (10–40 yrs)	67,094	67,017
Equipment (3–25 yrs)	122,662	114,099
Projects in process	395	1,217
	198,062	189,661
Less accumulated depreciation and amortization	(135,691)	(125,787)
Property and equipment, net	$ 62,371	63,874

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 32,634	32,332	302
Excess (deficiency) of revenues over expenses	12,846	12,414	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(363)	1	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 31,165	30,795	370

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 880	528	352
Excess (deficiency) of revenues over expenses	10,508	10,153	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(519)	(114)	(405)
Change in unrealized gains on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 32,634	32,332	302

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by the Act.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

		Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$	457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$	375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

		Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$	375	16,255	16,630
Investment return:				
Investment income		110	913	1,023
Net (depreciation) appreciation		(23)	264	241
Total investment return		87	1,177	1,264
Appropriation of endowment assets for expenditure		(5)	(751)	(756)
Endowment net assets, September 30, 2014	$	457	16,681	17,138

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	$ 261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	$ 375	16,255	16,630

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premiums held on deposit at end of year	$	15,115	10,544

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Preferred equity securities	—	—	—	—
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2024		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 280	276
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful use	2,962	1,149
Other	1,971	1,009
Total	$ 9,776	6,871

(19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,745	39,372
	$ 268,982	254,579

(20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

(21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current assets:						
Cash and cash equivalents	$ 24,610	823	—	364	—	25,797
Short-term investments	17	—	—	—	—	17
Current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Accounts receivable, net	26,816	2,999	(68)	381	68	30,196
Other current assets	6,108	253	5,749	17	(5,515)	6,612
Total current assets	58,696	4,075	10,484	762	(5,447)	68,570
Marketable securities	20,803	—	—	—	—	20,803
Assets whose use is limited:						
By donor and held in trust by others	15,696	—	—	—	—	15,696
For estimated self-insurance liability	—	—	41,038	—	—	41,038
By bond indenture	4,321	—	—	—	—	4,321
Net interest in Foundation	5,182	—	—	—	—	5,182
Other	6	—	—	—	—	6
Total assets whose use is limited	25,205	—	41,038	—	—	66,243
Less current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Noncurrent assets whose use is limited	24,060	—	36,235	—	—	60,295
Property and equipment, net	59,768	1,417	—	1,186	—	62,371
Other assets:						
Investments in joint venture arrangements	23,723	—	—	—	(13,699)	10,024
Deferred financing costs, net	103	—	—	—	—	103
Total other assets	23,826	—	—	—	(13,699)	10,127
Total assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

(Continued)

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current liabilities:						
Current portion of long-term obligations	$ 2,101	—	—	408	—	2,509
Accounts payable	16,795	432	—	25	—	17,252
Salaries, wages, and payroll withholdings	3,974	1,370	—	299	—	5,643
Due to third-party payors, net	783	—	—	—	—	783
Accrued expenses and other current liabilities	13,994	504	5,038	219	(5,447)	14,308
Total current liabilities	37,647	2,306	5,038	951	(5,447)	40,495
Long-term liabilities:						
Long-term obligations, net of current portion	17,818	—	—	73	—	17,891
Estimated self-insurance liability	3,278	—	28,536	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	—	72,182
Other long-term liabilities	9,464	59	—	—	—	9,523
Total long-term liabilities	102,742	59	28,536	73	—	131,410
Net assets (deficit):						
Unrestricted	27,668	3,127	13,145	924	(14,069)	30,795
Noncontrolling interest in subsidiaries	—	—	—	—	370	370
Total unrestricted	27,668	3,127	13,145	924	(13,699)	31,165
Temporarily restricted	2,415	—	—	—	—	2,415
Permanently restricted	16,681	—	—	—	—	16,681
Total net assets	46,764	3,127	13,145	924	(13,699)	50,261
Total liabilities and net assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HOSPITAL, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Revenues:						
Revenue from patient services, net of contractual allowances	$ 248,807	24,157	—	6,197	—	279,161
Provision for uncollectible accounts	(10,078)	(996)	—	—	—	(11,074)
Net revenue from patient services	238,729	23,161	—	6,197	—	268,087
Other operating revenues	8,706	4,039	5,070	16	(8,055)	9,776
Total revenues	247,435	27,200	5,070	6,213	(8,055)	277,863
Expenses:						
Salaries and wages	85,350	26,689	—	1,168	—	113,207
Employee benefits	24,562	3,778	—	280	—	28,620
Supplies and other expenses	106,022	9,260	4,092	3,370	(7,482)	115,262
Depreciation and amortization	9,888	283	—	284	—	10,455
Interest	1,405	—	—	33	—	1,438
Total expenses	227,227	40,010	4,092	5,135	(7,482)	268,982
Operating income (loss)	20,208	(12,810)	978	1,078	(573)	8,881
Nonoperating gains (losses):						
Investment income, net	2,279	—	1,545	—	—	3,824
Equity in earnings of joint ventures	3,359	—	—	—	(3,170)	189
Change in net assets of Foundation	281	—	—	—	—	281
Net loss on disposal of assets	(46)	—	—	—	—	(46)
Other	(856)	—	—	—	573	(283)
Total nonoperating gains (losses), net	5,017	—	1,545	—	(2,597)	3,965
Excess (deficiency) of revenues over expenses	25,225	(12,810)	2,523	1,078	(3,170)	12,846
Net assets released from restriction	(48)	—	—	—	—	(48)
Capital transactions, net	(14,778)	14,778	—	(910)	547	(363)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	—	(486)	—	486	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	—	(13,377)
(Decrease) increase in unrestricted net assets	$ (3,505)	1,968	2,037	168	(2,137)	(1,469)

See accompanying independent auditors' report.

Saint Mary's HOSPITAL

DAILY CENSUS & REVENUE REPORT

August 21, 2015

UNIT	DEPT	STAFFED BEDS	DAILY BUDGET Patient Days	DAILY ACTUAL Patient Days	DAILY ACTUAL Discharges	MTD BUDGET Patient Days	MTD ACTUAL Patient Days	MTD VAR Patient Days	MTD BUDGET Discharges	MTD ACTUAL Discharges	MTD VAR Discharges	MTD BUDGET Length of Stay	MTD ACTUAL Length of Stay	MTD VAR Length of Stay
Medical Acute SH5	3130	21	19	16	10	404	365	-10%	96	108	12%	4.20	3.38	20%
Behave Hlth Srvc OB1	3570	12	11	12	2	233	243	4%	45	43	-4%	5.21	5.65	-8%
Telemetry	3140	20	18	19	4	375	311	-17%	81	74	-8%	4.65	4.20	10%
OB-4 Ortho/Neuro	3150	30	22	25	5	457	324	-29%	113	88	-22%	4.04	3.68	9%
X-3 Medical Oncology	3320	26	23	-	-	489	329	-33%	96	89	-7%	5.08	3.70	27%
OB-7 General Surgery	3200	23	18	16	8	381	264	-31%	129	84	-35%	2.96	3.14	-6%
Critical Care Unit	3500	16	11	9	1	231	200	-13%	20	15	-24%	11.76	13.33	-13%
Cardiovascular Unit	3510	8	4	4	-	75	74	-2%	26	9	-65%	2.92	8.22	-182%
Labor/Delivery	4070	23	8	12	2	175	183	5%	64	71	10%	2.72	2.58	5%
Holding		-	4	9	1	92	76	-18%	8	3	-63%	11.33	25.33	-124%
OB/Gyn	3600	-	0	-	-	6	3	-51%	-	2	#DIV/0!		1.50	#VALUE!
SubTotal		**179**	**139**	**122**	**33**	**2,919**	**2,372**	**-19%**	**677**	**586**	**-13%**	**4.31**	**4.05**	**6%**
Neonatal ICU (Critical Care Nurs)	3750	9	4	3	-	76	74	-2%	8	9	11%	9.33	8.22	12%
Nursery	3700	23	6	11	2	134	148	10%	47	62	33%	2.87	2.39	17%
Birthing Center	4310	2	0	-	-	1	-	-100%	1	-	-100%	2.00		#VALUE!
SubTotal		**34**	**10**	**14**	**2**	**211**	**222**	**5%**	**56**	**71**	**28%**	**3.80**	**3.13**	**18%**
TOTAL (excl Psych and Nursery)		**178**	**132**	**113**	**31**	**2,763**	**2,203**	**-20%**	**642**	**552**	**-14%**	**4.31**	**3.99**	**7%**
GRAND TOTAL (incl Psych & Nursery)		**213**	**149**	**136**	**35**	**3,130**	**2,594**	**-17%**	**733**	**657**	**-10%**	**4.27**	**3.95**	**8%**

Adult & Peds Occupancy	78%	68%	78%	63%
NICU Occupancy	40%	33%	40%	39%
Nursery Occupancy	28%	48%	28%	31%
Total Occupancy	70%	64%	70%	58%

	DAILY BUDGET	DAILY ACTUAL	MTD BUDGET	MTD ACTUAL	MTD VAR
Observation	6	6	134	173	29%
OP Surgery	61	54	923	854	-7%
Outpatient/Ref Lab	481	452	7,628	7,539	-1%
Psych OP	5	1	75	41	-45%
Series/Recurring	22	19	342	747	118%
Urgent Care	73	59	1,396	1,206	-14%
O/P Visits (excl ER Visits)	**648**	**591**	**10,498**	**10,580**	**1%**
ER Visits (only includes discharges)	178	173	3,735	3,678	-2%
Total O/P Visits (incl ER Visits)	**826**	**764**	**14,233**	**14,258**	**0%**

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

CHARGE TOTALS:	Daily Budget	Daily Actual	Daily Proj Excess / Shortfall	MTD Budget	MTD Actual	MTD Proj Excess / Shortfall	YTD Budget	271400155.2	YTD Proj Excess / Shortfall
IP Actual	845,681	849,771	$4,090	17,759,299	15,514,430	($2,244,869)	268,562,483	275,230,061	$6,667,578
OP Actual	1,581,240	1,265,268	($315,972)	25,567,827	24,489,757	($1,078,070)	378,303,382	380,918,026	$2,614,644
Total	**$2,426,921**	**$2,115,039**	**($311,882)**	**$43,327,126**	**$40,004,186**	**($3,322,940)**	**$646,865,865**	**$656,148,086**	**$9,282,221**
Budget variance	**-12.9%**			**-7.7%**			**1.4%**		

	7/31/2015	8/21/2015	Change
IP Accounts Receivable	23,037,971	20,577,457	(2,460,514)
OP Accounts Receivable	28,730,929	34,881,657	6,150,728
ACCOUNTS RECEIVABLE:	**$51,768,900**	**$55,459,114**	**3,690,214**
IP Unbilled Receivable	7,098,463	9,088,554	1,990,091
OP Unbilled Receivable	16,718,641	14,714,253	(2,004,388)
UNBILLED RECEIVABLE:	**23,817,104**	**23,802,807**	**($14,297)**
	$75,586,004	**$79,261,921**	**$3,675,917**

Saint Mary's HOSPITAL

DAILY CENSUS & REVENUE REPORT

August 22, 2015

UNIT	DEPT	STAFFED BEDS	DAILY BUDGET Patient Days	DAILY ACTUAL Patient Days	DAILY ACTUAL Discharges	MTD BUDGET Patient Days	MTD ACTUAL Patient Days	MTD VAR Patient Days	MTD BUDGET Discharges	MTD ACTUAL Discharges	MTD VAR Discharges	MTD BUDGET Length of Stay	MTD ACTUAL Length of Stay	MTD VAR Length of Stay
Medical Acute SH5	3130	21	19	15	8	424	380	-10%	101	116	15%	4.20	3.28	22%
Behave Hlth Srvc OB1	3570	12	11	12	-	244	255	4%	47	43	-8%	5.21	5.93	-14%
Telemetry	3140	20	18	18	4	392	329	-16%	84	78	-8%	4.65	4.22	9%
OB-4 Ortho/Neuro	3150	30	22	24	9	479	348	-27%	119	97	-18%	4.04	3.59	11%
X-3 Medical Oncology	3320	26	23	-	-	512	329	-36%	101	89	-12%	5.08	3.70	27%
OB-7 General Surgery	3200	23	18	18	4	400	282	-29%	135	88	-35%	2.96	3.20	-8%
Critical Care Unit	3500	16	11	10	1	242	210	-13%	21	16	-22%	11.76	13.13	-12%
Cardiovascular Unit	3510	8	4	4	-	79	78	-1%	27	9	-67%	2.92	8.67	-197%
Labor/Delivery	4070	23	8	7	6	183	190	4%	67	77	14%	2.72	2.47	9%
Holding		-	4	4	1	97	80	-17%	9	4	-53%	11.33	20.00	-77%
OB/Gyn	3600	-	0	-	-	6	3	-53%	-	2	#DIV/0!		1.50	#VALUE!
SubTotal		179	139	112	33	3,058	2,484	-19%	710	619	-13%	4.31	4.01	7%
Neonatal ICU (Critical Care Nurs)	3750	9	4	3	-	79	77	-3%	9	9	6%	9.33	8.56	8%
Nursery	3700	23	6	7	5	141	155	10%	49	67	37%	2.87	2.31	20%
Birthing Center	4310	2	0	-	-	1	-	-100%	1	-	-100%	2.00		#VALUE!
SubTotal		34	10	10	5	221	232	5%	58	76	31%	3.80	3.05	20%
TOTAL (excl Psych and Nursery)		178	132	103	33	2,895	2,306	-20%	672	585	-13%	4.31	3.94	9%
GRAND TOTAL (incl Psych & Nursery)		213	149	122	38	3,279	2,716	-17%	768	695	-9%	4.27	3.91	8%

Adult & Peds Occupancy	78%	63%	78%	63%	
NICU Occupancy	40%	33%	40%	39%	
Nursery Occupancy	28%	30%	28%	31%	
Total Occupancy	70%	57%	70%	58%	

	DAILY BUDGET	DAILY ACTUAL	MTD BUDGET	MTD ACTUAL	MTD VAR
Observation	6	7	140	180	29%
OP Surgery	-	2	923	856	-7%
Outpatient/Ref Lab	110	107	7,738	7,666	-1%
Psych OP	-	-	75	41	-45%
Series/Recurring	-	2	342	749	119%
Urgent Care	50	61	1,446	1,267	-12%
O/P Visits (excl ER Visits)	166	179	10,664	10,759	1%
ER Visits (only includes discharges)	178	164	3,913	3,842	-2%
Total O/P Visits (incl ER Visits)	344	343	14,577	14,601	0%

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

CHARGE TOTALS:		Daily Budget	Daily Actual	Daily Proj Excess / Shortfall	MTD Budget	MTD Actual	MTD Proj Excess / Shortfall	YTD Budget	271400155.2	YTD Proj Excess / Shortfall
IP Actual		845,681	509,906	($335,775)	18,604,980	16,024,335	($2,580,645)	269,408,164	275,739,966	$6,331,803
OP Actual		308,205	400,631	$92,426	25,876,032	24,890,388	($985,644)	378,611,587	381,318,657	$2,707,070
Total		$1,153,886	$910,537	($243,349)	$44,481,012	$40,914,723	($3,566,289)	$648,019,751	$657,058,623	$9,038,872
Budget variance		-21.1%			-8.0%			1.4%		

	7/31/2015	8/22/2015	Change
IP Accounts Receivable	23,037,971	20,577,457	(2,460,514)
OP Accounts Receivable	28,730,929	34,881,657	6,150,728
ACCOUNTS RECEIVABLE:	$51,768,900	$55,459,114	3,690,214
IP Unbilled Receivable	7,098,463	9,598,460	2,499,997
OP Unbilled Receivable	16,718,641	15,114,884	(1,603,757)
UNBILLED RECEIVABLE:	23,817,104	24,713,344	$896,240
	$75,586,004	$80,172,458	$4,586,454

843

EXHIBIT S6

Schedule H, Part I, Section 7 - Financial Assisstance

		FY 2014	3% FY 2015	3% FY 2016
a	Financial Assistance at cost	328,346	338,196	348,342
b	Medicaid	13,083,195	13,475,691	13,879,962
c	Cost of other means-tested government programs		-	
d	Total Financial Assistance	13,411,541	13,813,887	14,228,304
	Other Benefits		-	
e	Community health improvement services and community benefit operations	147,207	151,623	156,172
f	Health professions education	2,658,321	2,738,071	2,820,213
g	Subsidized health services	1,386,130	1,427,714	1,470,545
h	Research	165,239	170,196	175,302
i	Cash and in-kind contributions for community benefit	70,911	73,038	75,229
j	Total Other Benefits	4,427,808	4,560,642	4,697,462
k	Total	17,839,349	18,374,529	18,925,765

Schedule H, Part II - Community Building Activities

		FY 2014	FY 2015	FY 2016
1	Physical improvements and housing	202	208	214
2	Economic development			
3	Community support			
4	Environmental improvements			
5	Leadership development and training for community members			
6	Coalition building			
7	Community health improvement advocacy			
8	Workforce development	169,504	174,589	179,827
9	Other			
10	Total	169,706	174,797	180,041

3%	3%
FY 2017	**FY 2018**
358,793	369,556
14,296,360	14,725,251
14,655,153	15,094,808

160,857	165,683
2,904,819	2,991,964
1,514,662	1,560,102
180,561	185,978
77,486	79,811
4,838,385	4,983,537
19,493,538	20,078,344

FY 2017	**FY 2018**
221	227
185,222	190,778
185,442	191,006

EXHIBIT S7

SAINT FRANCIS Care Policy and Procedure	**Title:** **Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired.**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☒ Saint Francis Medical Group, Inc. ☒ Saint Francis *Care* Medical Group, P.C. ☒ Asylum Hill Family Medicine Center, Inc. ☒ Saint Francis Behavioral Health Group, P.C. ☒ Saint Francis Emergency Medicine Group, P.C.	**Proponent Department** Patient Care	**Number** CLIN.0121	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☐ **Administrative** ☒ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 6/25/2015	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE:

The purpose of this policy is to help ensure quality Patient care by providing guidelines and procedures to assist Saint Francis Personnel (defined below) in providing Effective Communication (defined below) to individuals who are limited English proficient, visually impaired, deaf or hard of hearing, speech impaired, or who have any other disability impairing their ability to communicate (a "Language Service Need").

SCOPE:

This policy applies to all Saint Francis Personnel in their communications with Patients or Companions (defined below) in all acute care and ambulatory clinical areas of the above referenced entities (collectively, "Saint Francis").

DEFINITIONS:

1. The term **"Auxiliary Aids and/or Services"** includes, but is not limited to Qualified Interpreters in-person or through Video Remote Interpreting (VRI) services; note-takers; computer-assisted real time transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices and systems; telephone compatible hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text and video-based telecommunication products and systems, including text telephones (TTYs/TDDs), videophones and captioned telephones; or other methods of ensuring Effective Communication with individuals who are deaf or hard of hearing.

2. The term "**Companion**" means a person who is one of the following:

- a person whom the Patient designates to communicate with Saint Francis Personnel on his or her behalf regarding the Patient's condition or care or to help the Patient act on the information, advice or instructions provided by Saint Francis;
- a person legally authorized to make health care decisions on behalf of the Patient; or
- such other family member, friend, or associate of a Patient who, along with the Patient, is an appropriate person with whom Saint Francis should communicate.

3. The term "**Effective Communication**" means communication that is as clear and understandable to individuals with Language Service Needs as it is for individuals without. More specifically it means the successful joint establishment of meaning wherein Patients/Companions and health care providers exchange information, enabling

Patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both Patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from Patients, and when Patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care. For communication to be effective it must be, timely, provided in a manner and medium appropriate to the significance of the message and the communication abilities of the Patient/Companion.

4. The term "**Non-scheduled Request**" means a situation in which there is less than two (2) hours between the time when a Patient or Companion who is deaf or hard of hearing makes a request for an interpreter and when the services of an interpreter are necessary.

5. The term **"Patient"** means any individual who is seeking or receiving health care services (whether on an inpatient or outpatient basis, including consultations, treatment, scheduling of appointments, discussion of billing issues, attending health education classes, and other health care services) from Saint Francis.

6. The term **"Qualified Interpreter"** means an interpreter who, via a VRI service, telephone, or an onsite appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators. Not all interpreters are qualified for all situations. For example, an interpreter who is qualified to interpret using American Sign Language is not necessarily qualified to interpret orally. Someone who has only a rudimentary familiarity with sign language or finger spelling is not a "Qualified Interpreter" under this Agreement. Likewise, someone who is fluent in sign language but who does not possess the ability to process spoken communication into the proper signs or to observe someone else signing and change his or her signed or finger-spelled communication into spoken words is not a qualified sign language interpreter.

7. The term **"Scheduled Incident"** means situations in which there are two (2) or more hours between the time when an appointment is scheduled and when the services of the a Qualified Interpreter are required.

8. The term **"Saint Francis Personnel"** means all employees and independent contractors with contracts to work for Saint Francis, including, without limitation, nurses, physicians, social workers, technicians, admitting personnel, receptionists, telephone operators, billing staff, security staff, counselors, and therapists, and all volunteers, who have or are likely to have direct contact with Patients or Companions as defined herein. The term also includes all affiliated physicians or other health care professionals who have medical staff privileges that permit them to see and/or treat Patients at Saint Francis. Saint Francis will ensure that all Saint Francis Personnel receive training in Language Services appropriate to their role and level of direct contact with Patients and Companions.

9. The term **"Video Remote Interpreting" ("VRI")** means an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images and meets other requirements as provided in 28 C.F.R. §36.303(f).

POLICY:

Commitment to Provide Effective Communication

Saint Francis shall provide its Patients and their Companions with Effective Communication and an equal opportunity to participate fully in the benefits, activities, programs and services provided by Saint Francis in a timely manner and in such a way as to protect the privacy and independence of the individual.

Where necessary to ensure Effective Communication, Saint Francis shall provide appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, to Patients and Companions who are Limited English Proficient (LEP), visually impaired, deaf or hard of hearing, speech impaired or who have another disability which impairs their ability to communicate (collectively, "Language Service Needs"). Saint Francis shall make a site specific determination of which Auxiliary Aids and/or Services will be available at each of its separate locations.

Patients and Companions of Saint Francis, who are LEP shall have services provided to them in their primary language or have appropriate Auxiliary Aids and/or Services, including the services of a Qualified Interpreter provided to them during the delivery of all significant healthcare and related support services.

All Auxiliary Aids and/or Services shall be available within a reasonable time, at no cost to Patients as needed to provide Effective Communication.

Assessment of Communication Needs:

Assessment of Need for Auxiliary Aids and/or Services. Saint Francis Personnel shall perform an assessment to determine whether the Patient or Companion requires Auxiliary Aids and/or Services to ensure Effective Communication ("Assessment of Language Needs"). If there is any indication from such initial assessment, inquiry, or Saint Francis Personnel's observations of the Patient or Companion, that the Patient or Companion has a Language Service Need, Saint Francis Personnel shall perform an assessment to determine which appropriate Auxiliary Aids and/or Services are needed in order to ensure Effective Communication. In determining which Auxiliary Aids and/or Services are necessary to ensure Effective Communication, and the timing, duration, and frequency with which they will be provided, Saint Francis Personnel shall consult with the Patient or Companion who has a Language Service Need. The assessment shall consider and take into account all relevant facts and circumstances, including without limitation the following:

- the Patient's or Companion's request for, stated need, or preference for, a Qualified Interpreter or other specific Auxiliary Aids and/or Services;
- the nature, length, complexity, and importance of the communication at issue;
- the individual's disability and communication skills and knowledge;
- the Patient's health status or changes thereto;
- the reasonably foreseeable health care activities of the Patient (e.g., medical tests or procedures, rehabilitation services, meetings with health care professionals or social workers, discussions regarding billing, insurance, self-care, prognoses, history, and discharge); and
- any factors relevant to determine whether the specific type of Auxiliary Aid and/or Service is effective under the circumstances as set forth below.

A list of communication options will be provided to the Patient/Companion to determine their preferred communication method(s). A Patient or Companion with a Language Service Need may prefer to use lip reading, paper and pencil or pictorial cards during the initial Assessment of Language Need.

Timing of Assessment and Determination. Saint Francis Personnel shall provide the initial Assessment of Language Needs at the first point at which a Patient accesses services at Saint Francis (emergency department registration, admissions, etc.). Saint Francis shall incorporate the Assessment of Language Needs into its electronic medical record and its intake procedures and document its determination in the patient's medical record, including substantially all of the elements set forth in the Communication Assessment and Waiver attached hereto as Attachment A. The Assessment of Language Needs shall be conducted at the earliest of the following:

- the time an appointment is scheduled;
- the time Saint Francis becomes aware that a Patient or Companion who has a Language Service Need

who may require Auxiliary Aids and/or Services is being transferred or transported to Saint Francis; or

- the time the Patient or Companion initially arrives at Saint Francis or encounters Saint Francis Personnel.

Ongoing Assessment and Redetermination. On an on-going basis, Saint Francis Personnel shall reassess their determination of whether Effective Communication is being provided, in consultation with the Patient or Companion who has a Language Service Need, when the Patient or Companion indicates that communication has not been effective, or when Saint Francis Personnel's observations suggest that communication has not been effective. The on-going Assessment of Language Needs shall be conducted during Patient care as needed and the Auxiliary Aids and/or Services shall be amended if required based on the findings of the on-going assessment.

Continuation of Provision of Appropriate Auxiliary Aids and/or Services for Continued Hospitalizations and Subsequent Visits. If a Patient or Companion who has a Language Service Need has an ongoing relationship with Saint Francis, with respect to each of the subsequent visits, Saint Francis shall continue to provide appropriate Auxiliary Aids and/or Services to the Patient or Companion during the entire period of the Patient's hospitalization and/or outpatient visits, without requiring subsequent assessments or requests for the appropriate Auxiliary Aids and/or Services by the Patient or Companion unless the Patient or Companion indicates otherwise.

Documentation of Assessment and Determination. The Assessment and determination of Language Needs shall be documented in the Patient's medical record. The Patient's medical record shall be conspicuously labeled to alert Saint Francis Personnel to the fact that the Patient or Companion has a Language Service Need and any Auxiliary Aids and/or Services that have been identified as necessary to Provide Effective Communication with the Patient or Companion.

Determination Not to Provide Requested Auxiliary Aid or Service. If, after conducting the Assessment of Language Needs, Saint Francis determines that it will not provide a particular Auxiliary Aid or Service requested by a Patient or Companion who has a Language Service Need, Saint Francis Personnel shall so advise the individual requesting the Auxiliary Aid or Service. In the event that an Auxiliary Aid or Service is necessary for Effective Communication and Saint Francis Personnel determine that they will not provide the Auxiliary Aid or Service requested by the Patient or Companion who has a Language Service Need, Saint Francis Personnel will secure and provide the Patient or Companion with another means of Effective Communication. Saint Francis Personnel shall document in the Patient's medical record the basis for the determination, including the date of the determination; the name and title of the Saint Francis Personnel who made the determination; and the alternative Auxiliary Aid or Service, if any, that Saint Francis provided.

Exchange of written notes. In determining whether the exchange of written notes, using either paper and pen or a mobile device, is Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include the Patient's or Companion's fluency in written English.

Lip Reading. In some circumstances, lip reading may be a means of Effective Communication. In determining whether communication using lip reading is appropriate and Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include:

- the Patient's or Companion's fluency in English;
- the Patient's or Companion's competency in lip reading; and
- whether the Patient or Companion has residual hearing.

<u>Provision of Qualified Interpreter Services</u>:

Provision of Qualified Interpreter. Saint Francis shall provide a Qualified Interpreter to a Patient or Companion whenever needed for Effective Communication. The following are examples of circumstances when it is necessary to provide Qualified Interpreters:

- Obtaining a Patient's medical history or description of symptoms and medical condition;
- Discussing or explaining a Patient's diagnosis, current condition, prognosis, treatment options or recommendation for treatment;
- Explaining Patient rights and responsibilities;
- Discussing or explaining procedures, tests, or treatments;
- Discussing or explaining test results;
- Discussing or explaining prescribed medications, instructions for how and when medication is to be taken, and possible side effects and interactions of medications;
- Obtaining informed consent or permission for procedures, surgery, or other treatment options;
- Communicating during treatment and testing;
- Communicating during discharge or post-operative planning and instruction;
- Providing mental health evaluations, group or individual therapy, counseling or other therapeutic activities, including, but not limited to, grief counseling and crisis intervention;
- Providing information about blood or organ donations;
- Explaining living wills or powers of attorney (or their availability);
- Discussing financial or insurance matters related to payment for services;
- Providing educational presentations, such as classes concerning birthing, nutrition, cardiopulmonary resuscitation (CPR), and weight management;
- Any other circumstance in which a Qualified Interpreter is necessary to ensure a Patient's rights provided by the law.

The foregoing list of circumstances is not exhaustive and does not imply that there are no other circumstances when it may be appropriate to provide Auxiliary Aids and/or Services for Effective Communication.

Acceptable methods for the provision of Qualified Interpreter and translation services include, but are not limited to the following:

- Telephone-based interpreting- delivered via telephonic technology
- Video Remote interpreting (VRI)- video conference with a Qualified Interpreter (including but not limited to American Sign Language (ASL))
- In-person interpreting- provided onsite by a Qualified Interpreter (including ASL)
- Written translation of vital and non-vital documents (vital documents as determined by the Joint Commission, Department of Health and Human Services and other regulatory agencies)

Whenever possible, arrangements for Qualified Interpreters/equipment should be made in advance when Patients have scheduled appointments. Telephone Qualified Interpreter services are available on each unit and will be used whenever appropriate if there is a delay in the delivery of resources. For deaf and hard of hearing Patients the VRI resources can be used if there is a delay in arrival of in-person resources.

The following resources and/or devices may be utilized at **no charge to the Patient.**

A. <u>Deaf or Hard of Hearing</u>

Pictorial Cards (located in the language resource box)
Amplified Handset/Volume Control Telephone

Large Button Telephones
Telephone Typewriter (TTY)
Video Remote Interpreter (VRI) (With Qualified Interpreter communication including but not limited to ASL)
Contracted onsite Qualified Interpreters (including but not limited to ASL)

B. Visually Impaired

Braille Telephones

C. Limited English Proficient

- Pictorial Cards (located in the language resource box)
- Telephone interpreting (telephone based language interpretation)
- Video Remote interpreting (including but not limited to ASL)
- In-person interpreting (including but not limited to ASL)
- Written translated documents

Procedures for Obtaining Language Service Resources

Procedure For Obtaining A Telephone Qualified Interpreter:
If the Patient wishes to utilize the telephone Qualified Interpreter, Saint Francis Personnel will phone the hospital operator by dialing **'0'** from any phone and request to be connected to language resources. Dual handset phones are available on all units that are preprogrammed to dial language resources directly.

The requesting staff will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

Procedure For Obtaining A Video Remote Interpreter (VRI) Device:
The requesting staff shall first make a determination as to whether communication using VRI is appropriate and effective. Relevant factors in making such determination include whether:

- The Patient or Companion is limited in his or her ability to see the video screen;
- The Patient or Companion has limited ability to move his or her head, hands, or arms; vision limitations, cognitive or consciousness issues, or pain issues;
- There are multiple people in a room and the information exchanged is highly complex or fast-paced;
- The Patient or Companion may move repeatedly to areas of Saint Francis that do not have a designated high speed internet line; and
- The Patient will be treated in a room where there are space restrictions.

1. If the requesting staff determines that VRI is appropriate, they shall phone the hospital operator, dial '0'

and request the VRI device be brought to the Patient.

The requesting Saint Francis Personnel shall provide the following:

- Name and telephone number of requester,
- Department - including campus and address,
- Patient name and reason for visit,
- Date, time and approximate length of time needed,
- Additional assistance that may be needed

2. The hospital operator will validate that the Patient is in an area that has wireless communication.

3. The hospital operator will notify the storeroom via phone to request the VRI device on behalf of the Patient.

4. The VRI device will be deployed to the requesting department within 10 minutes, if available. Storeroom staff will complete the storeroom VRI device log.

5. The equipment will be placed in a location that is easily viewed by both the Patient and the Saint Francis Personnel, generally near the foot of the bed or stretcher (or according to Patient abilities), with the Saint Francis Personnel standing near the Patient at the head of the bed during the interpretation session.

6. The Saint Francis Personnel will initiate the connection and answer a number of required questions such as Patient's name, medical record number, location, etc. before beginning the interpretation session.

7. Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of the response in the medical record. In the event that the Patient or Companion cannot communicate effectively using any VRI service and alternative resource will be employed.

8. The VRI will facilitate communication between the Saint Francis Personnel and the Patient/Companion. NOTE:

a. The camera and sound system will pick up EVERYTHING that is said and done in the room and EVERYTHING will be interpreted to the Patient. There is no selective interpreting.

b. In the event of a system connectivity failure, the Saint Francis Personnel should notify the operator of equipment failure, the operator will request technical support and/or request a replacement VRI. In the event that a repair or replacement VRI is not available in a timely manner Saint Francis Personnel shall obtain an alternative means of Effective Communication in accordance with this policy or follow the procedures outlined below for Interim Services until a repair or replacement VRI is secured.

9. The same Patient may require the VRI device several times during a single hospital visit. The Saint Francis Personnel must disconnect at the end of each session or whenever they leave the room and reconnect as needed to start a new session.

10. The Saint Francis Personnel must document in the Patient's medical record each time the equipment is utilized with dates and start and stop times of each interpretation session and effectiveness of communication method.

11. When the VRI equipment is no longer required, the Saint Francis Personnel will place the VRI in the dirty laundry area for pick up by storeroom staff.

Saint Francis shall ensure that VRI services are provided in accordance with the following standards:

- real-time, full-motion video and audio over a dedicated, high-speed, wide-bandwith video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
- a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating Patient or Companion's face, arms, hands, and fingers, regardless of his or her body position;
- a clear, audible transmission of voices;
- ensure that the interpreter providing VRI is a Qualified Interpreter who is capable of communicating effectively with the Patient or Companion; and
- users of the technology and other involved individuals are adequately training so that they may quickly and efficiently set up and operate the VRI.

Once the VRI is operating, Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of his or her response. In the event that the Patient or Companion cannot communicate effectively using any VRI service the Hospital elects to acquire and offer, Saint Francis shall make all reasonable efforts to locate an in-person Qualified Interpreter or other Auxiliary Aid or Service that will provide Effective Communication; periodically inform the Patient or Companion of the status of those efforts; and document the concern and the steps taken to locate a Qualified Interpreter.

Procedure For Obtaining An In-Person Qualified Interpreter (including ASL):
The requesting Saint Francis Personnel will phone the hospital operator, dial '0' to request in-person Qualified Interpreter services. Operators will schedule these services including in-person Qualified Interpreters and will provide requesting Saint Francis Personnel with approximate time of arrival. They may or may not be immediately available due to weather restrictions etc., however, all services will be provided within a two hours of Non-scheduled Requests. If an in-person ASL Qualified Interpreter is not available, the VRI will be used for ASL Interpretation and the reason why the in-person Qualified Interpreter was not available must be noted in medical record. In the event that an Auxiliary Aid and/or Service is necessary and Saint Francis Personnel determines that it will not provide a particular Auxiliary Aid and/or Service requested by the Patient or Companion who has a Language Service Need, the requesting Saint Francis Personnel shall document the basis for the determination, including the date of the determination, the name and title of the Saint Francis Personnel who made the determination, and the alternative Auxiliary Aid and/or Service, if any, that Saint Francis decided to provide, in an Auxiliary Aid and Service Log. A copy of this documentation shall be retained and a copy shall be provided to the Patient or Companion upon request.

The requesting Saint Francis Personnel will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

The Saint Francis Personnel will document the arrival time of the Qualified Interpreter in the Patient's medical record

including the length of time for the interpretive session and effectiveness of the communication method. Each interpretive session must be documented separately. The same Patient may require the Qualified Interpreter several times during a single hospital visit, as additional communications are needed.

Procedure for the Provision of Written Translations:

1. Vital documents as defined by the Joint Commission and the Department of Health and Human Services will be translated and made available to Patients/Companions. These documents include but are not limited to:
    - Patient Rights and Responsibilities
    - Informed Consent
    - Advanced Directives
    - HIPPA Forms
    - Discharge Instructions
    - Release of Information
    - Notices pertaining to denial, reduction, modification or termination of services
    - Grievance forms

    Documents will be translated into each primary language used by more than 15% percent of the Patient population (each a "Frequently Utilized Language"). This will be assessed on an annual basis.

Provision of Qualified Interpreters in a Timely Manner:

When an interpreter is necessary for Effective Communication, Saint Francis shall ensure that Qualified Interpreters are provided in a timely manner.

Provision of Qualified Interpreter for Scheduled Incidents. For Scheduled Incidents, when a Qualified Interpreter is necessary to ensure Effective Communication, Saint Francis shall make a Qualified Interpreter available at the time of the appointment. If a Qualified Interpreter fails to arrive for the appointment, Saint Francis shall immediately contact the Qualified Interpreter service or another resource to arrange for another Qualified Interpreter.

Provision of Qualified Interpreter for Non-scheduled Requests. For Non-scheduled Requests, Saint Francis shall make a Qualified Interpreter available as soon as practicable, but no later than (a) two (2) hours from the time the request for an in-person Qualified Interpreter is made or (b) within fifteen (15) minutes of the request for a Qualified Interpreter when providing a Qualified Interpreter through VRI.

Interim Services. Between the time a Qualified Interpreter is requested and the time a Qualified Interpreter arrives, Saint Francis Personnel shall continue to try to communicate with the Patient or Companion who is deaf or hard of hearing for such purposes and to the same extent as they would have communicated with an individual without a disability, using all methods of communications. Saint Francis shall inform such Patient (or a Companion, if such Patient is unavailable) of the current status of efforts being taken to secure a Qualified Interpreter on his or her behalf. This section is not intended to delay the provision of appropriate medical care and services.

Provision of Qualified Interpreter throughout Hospitalization. Saint Francis shall provide a Qualified Interpreter throughout the admission of a Patient as necessary to achieve Effective Communication with such Patient or their Companion.

Communication Restrictions:

Restricted Use of Minors to Facilitate Communication. Saint Francis shall not rely on a minor accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or

Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public and where there is no Qualified Interpreter available.

Limited Use of an Adult Accompanying a Patient or Companion to Facilitate Communication. Saint Francis shall not require a Patient or Companion to bring another individual to interpret for him or her. Saint Francis Personnel may not rely upon an adult accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no Qualified Interpreter available or unless the following four factors are present:

- where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication and such person agrees to provide such assistance;
- such use is necessary or appropriate under the circumstances, giving appropriate consideration to any privacy and confidentiality issues that may arise;
- the Patient or Companion has been made aware of Saint Francis's full range of Auxiliary Aids and/or Services available free of charge; and
- the Patient or Companion provides written confirmation, substantially in the form of the Waiver of Interpreter Services Provided by Saint Francis attached hereto as Attachment A, that he or she was made aware of relevant Auxiliary Aids and/or Services available free of charge and agrees to the use of such person to interpret or facilitate communication. In such situations, Saint Francis shall retain the above-required written documentation in the Patient's medical record.

Notices:
Saint Francis shall develop, and post in conspicuous locations, notices that advise Patients and their families of the availability of Qualified Interpreters, the procedure for obtaining a Qualified Interpreter and the telephone numbers where complaints may be filed concerning Qualified Interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. All areas of first Patient contact shall be equipped with Language Determination Cards to assist Patients in identifying the Patient's primary language if communication barriers prevent Saint Francis Personnel from effectively determining the language of the Patients/Companions.

Training
New employees of Saint Francis will be trained in the procedure for the acquisition of Qualified Interpreter services during their employee orientation. Training on this procedure for current Saint Francis Personnel is required on an annual basis via on-line Health Stream training. In-person training is available on request to all Saint Francis departments, units and programs that require further assistance. Quarterly trainings will be held for the operators to ensure they are updated on all language services. Operators will fulfill the 24/7 requirement of an in-person language services point-person (with Clinical Resource Coordinators as back up) when the Language Services Program Administrator is off-site.

A poster outlining the availability of language services has been installed at all nursing stations and other points of Patient registration throughout the hospital and The Language Services Program Administrator (defined below), or his/her designee, shall conduct bi-monthly audits of such signage to ensure it remains in place and updated as necessary.

The Language Services Program Administrator shall conduct an annual review of the Language Services Needs of the Patient population. Following such review, the Language Services Program Administrator shall update the list of Frequently Utilized Languages and recommend any necessary changes to this policy.

Language Services Program Administrator
Saint Francis has designated a program administrator (the "Language Services Program Administrator"). The

Language Services Program Administrator, or his/her designee shall be available twenty-four (24) hours a day, seven (7) days a week, to answer questions and provide appropriate assistance regarding immediate access to, and proper use of, the appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, required by this policy. The Program Administrator may be reached at (860) 714-7004 or, for non-urgent enquiries, via email @ [*EMAIL ADDRESS*]. Auxiliary Aids and/or Services can be requested by dialing the Saint Francis operator (860) 714-4000 or "0" internally. Additional information on language services may be found on the Language Services website, by clicking the "3+1 Language Services Program" icon on the Saint Francis Infonet.

STATUTORY, REGULATORY OR OTHER REFERENCES/POLICY CROSS REFERENCE:

Section 504 of the Rehabilitation Act of 1973
Title III of the Americans with Disabilities Act (ADA)

CROSS REFERENCES:

Disability Discrimination Complaint and Grievance Policy

APPROVED BY: Policy requires Vice President approval.

Vice President(s):	Date:	Committee(s), if applicable:	Date:
Patti LaMonica, R.N. M.S.N. Interim Vice President Professional Nursing Practice and Quality Interim Chief Nursing Officer Executive Director Emergency and Pre-hospital Service Line	6/25/2015	Surendra P. Khera MD MSc Vice President, Medical Affairs Chief Medical Officer |Chief Quality Officer Vice-Chair, Department of Medicine.	6/25/2015

REPLACES:

Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired, 4/16/2015

KEY CHANGES:

Procedures for request of services broadened and clarified.

Attachment A

Communication Assessment and Waiver

It is the policy of Saint Francis to provide Auxiliary Aids and/or Services free of charge to ensure effective communication with Patients and Companions who are deaf, are hard of hearing, or have speech disabilities. We ask these questions so we may communicate effectively with you.

Patient's Name: _____

Name of Person with Disability (if not Patient): _____

Completed by: _____ Date & Time: _____ am/pm

Nature of Disability:

- ❑ Deaf
- ❑ Hard of Hearing
- ❑ Speech Disability
- ❑ Other (explain) _____

Relationship to Patient:

- ❑ Self
- ❑ Family Member
- ❑ Friend
- ❑ Other (explain) _____

Is a Qualified Interpreter necessary to assist in communicating with Hospital staff?

❑ Yes. Choose type:
❑ American Sign Language (ASL)
❑ Signed English
❑ Oral interpreter
❑ Cued speech
❑ Other (explain) _____

❑ No. Choose one:
❑ I do not use sign language or do not use an interpreter.
❑ I prefer to have family members/friends help with communication.
❑ I do not feel an interpreter is necessary or do not want one for this visit.
❑ Other (explain) _____

If you select No, please complete the Waiver of Interpreter Services (below).

All Communication Services will be provided FREE OF CHARGE.

If you requested an interpreter, do you have a preference between an in-person interpreter or a VRI?

❑ Yes, I prefer an interpreter in-person.

❑ Yes, I prefer video remote interpreter.

❑ No, I do not have a preference between the two.

Are other Auxiliary Aids and/or Services necessary for assisting with communication? Select all that apply:

❑ TTY/TDD (text telephone)

❑ Assistive listening device (sound amplifier)

❑ Qualified note-takers

❑ Exchange of written notes (writing back-and-forth)

❑ Relay

❑ CART (Computer-assisted Real Time Transcription Service)

❑ Other (explain) _____

If you have any questions, please call_____(voice),_____(TTY).

Signature_____Date & Time _____ Relationship to Patient_____

WAIVER OF INTERPRETER SERVICES PROVIDED BY SAINT FRANCIS

It is your choice whether you use an interpreter provided by Saint Francis. You are indicating that Saint Francis has offered to provide you with an interpreter, free of charge, and that you have declined Saint Francis offer.

❑ I waive my right to request that [*name of facility*] provide me an interpreter for this specific encounter.

❑ I have been informed of range of auxiliary aids and services that are available free of charge.

❑ I have been informed that [*name of facility*] does not require a Patient or Companion to bring someone to interpret for him or her.

❑ I request that_____(name of individual to interpret for Patient or Companion) to interpret or facilitate communications between [*name of facility*] personnel and the Patient or Companion.

Signature_____Date & Time _____ Relationship to Patient_____

If at any point during your Hospital visit, you wish to change any of the answers to the questions on this form or revoke your waiver, please notify_____.

EXHIBIT S8

The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review

Glenn Flores
Medical College of Wisconsin

Abstract

Twenty-one million Americans are limited in English proficiency (LEP), but little is known about the effect of medical interpreter services on health care quality. A systematic literature review was conducted on the impact of interpreter services on quality of care. Five database searches yielded 2,640 citations and a final database of 36 articles, after applying exclusion criteria. Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpreter services can have serious consequences for patients with mental disorders. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

Published in Medical Care Research Review

Med Care Res Rev **June 2005** vol. 62 no. 3 **255-299**

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

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ONE HUNDRED AND THIRD ASSEMBLY DISTRICT

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PUBLIC HEATH COMMITTEE
VETERANS' AFFAIRS COMMITTEE

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10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

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State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ROBERT SAMPSON
EIGHTIETH ASSEMBLY DISTRICT

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JUDICIARY COMMITTEE

10/26/2015

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Sincerely,

Representative Rob Sampson
80th District

State of Connecticut
SENATE

SENATOR HENRI MARTIN
THIRTY–FIRST SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
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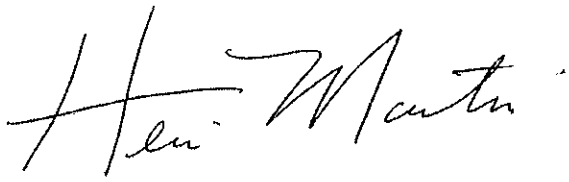

Senator Henri Martin
31st District

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

November 4, 2015

The Honorable Henri Martin
Senate Minority Whip
31st Senate District
State of Connecticut
Legislative Office Building, Suite 3400
Hartford, CT 06106-1591

Re: Certificate of Need
Saint Mary's application to sell its assets to Trinity Health Corporation

Dear Senator Martin:

On November 2, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket once it is received. Please be advised, that once a hearing has been scheduled it will be posted on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Connecticut Department of Public Health

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Hartford, Connecticut 06134-0308
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Jewel Mullen, M.D., M.P.H., M.P.A.
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Dannel P. Malloy
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Lt. Governor

November 4, 2015

The Honorable Al Adinolfi
Assistant Republican Leader
103rd Assembly District
State of Connecticut
Legislative Office Building, Room 4200
Hartford, CT 06106-1591

Re: Certificate of Need
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Dear Representative Adinolfi:

On October 26, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

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Lt. Governor

November 4, 2015

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Representative
80th Assembly District
State of Connecticut
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Hartford, CT 06106-1591

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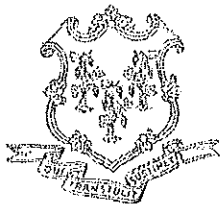

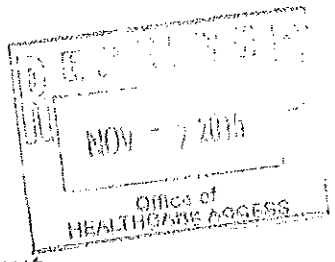

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31st District

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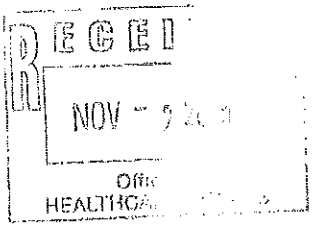

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ROBERT SAMPSON
EIGHTIETH ASSEMBLY DISTRICT

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10/26/2015

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80th District

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As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

ST. FRANCIS XAVIER RECTORY
625 BALDWIN STREET
WATERBURY, CONNECTICUT 06706
(203) 756-7804 ◦ Fax (203) 756-7805

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NOV 13 2015
Office of
HEALTHCARE ACCESS

November 12, 2015

Kimberly R. Martone, Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding *it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with* Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Paul J. Pace
Pastor

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RECEIVED
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REPRESENTATIVE CRAIG A. MINER
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

HOME: (860) 567-4757
CAPITOL: (800) 842-1423
Craig.Miner@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
State Representative
66th District

NOSS
Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery
Michael E. Karnasiewicz, MD, ABNS
Neurosurgery & Spine Care
Jarob N. Mushaweh, MD, ABNS
Neurosurgery & Spine Care
Alan S. Waitze, MD, ABNS
Neurosurgery & Spine Care
John G. Strugar, MD
Neurosurgery & Spine Care
David L. Forshaw, MD
Neurosurgery & Spine Care
Judith L. Gorelick, MD, FAANS, FACS
Neurosurgery & Spine Care

Orthopaedics
Glenn G. Taylor, MD, ABOS
Orthopaedic Surgery & Spine Care
William F. Flynn, Jr., MD, ABOS
Joint Reconstruction & Sports Medicine
Frederick J. Watson, MD, ABOS
Orthopaedic Surgery & Sports Medicine

Pain Management
and Rehabilitation
Tamer B. Ghaly, MD
Interventional Pain Management
Thomas Mathew, MD
Interventional Physiatry
Alisa H. Darling, MD, ABPMR
Physical Medicine & Rehabilitation
Electrodiagnostic Medicine
Mark A. Mashia, DC, MS
Chiropractic Physician, Acupuncture

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November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System.

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

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Office of
HEALTHCARE ACCESS

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

The healthcare environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis, together with their ultimate acquisition by Trinity Health Corporation, will give both Catholic hospitals the support that is essential to be successful. Together they plan to improve the infrastructure and capabilities required to deliver value-based accountable care; improve population health; enhance the quality of care; reduce the cost of healthcare; expand services; and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent, and capital to keep the safety network for healthcare alive and well. While Saint Mary's is a strong hospital, the demands of the new healthcare laws and high cost of

technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,

Larry B. Butler

Larry B. Butler
State Representative

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

December 2, 2015

The Honorable Larry B. Butler
Representative -72nd District
House of Representatives
Legislative Office Building
Hartford, CT 06106-1591

Re: Certificate of Need Docket Number 15-32045-CON
Saint Mary's Health System
Saint Mary's application to sell its assets to Trinity Health-New England, Inc.

Dear Representative Butler:

On November 27, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Health System's application to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

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Office of
HEALTHCARE ACCESS

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

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technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,

Larry B. Butler

Larry B. Butler
State Representative

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: December 16, 2015

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.
Transfer of Ownership and Control to Trinity Health-New England, Inc.,
formerly known as Saint Francis Care, Inc.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Thursday, December 24, 2015 2:32 PM
To: 'chartley@stfranciscare.org'; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information
Attachments: 15-32045 Completeness Letter 12.24.15.pdf

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 24, 2015

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Dadlez and Mr. Anthony:

On November 25, 2015, the Office of Health Care Access received a Certificate of Need application filing on behalf of Saint Mary's Health System ("SMHS") and New England Regional Health Ministry ("NE-RHM"), a subsidiary of Trinity Health Corporation ("THC"), for NE-RHM to acquire SMHS and its assets. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **February 22, 2016**, otherwise your application will be automatically considered withdrawn.

OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a-639a(c) and requests the following additional information:

1. What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.

2. Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.

3. Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.

4. According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.

5. What entity will be doing the billing for Saint Mary's if the CON is approved?

6. Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.

7. With respect to the $100 million capital expenditure and two additional $10 million payments:

    a) List all sources of funding and financing.
    b) What portion of the payment will be derived from Saint Mary's operational revenue?
    c) Is payment of the full $100 million amount contingent upon financial performance?
    d) Will Saint Mary's future income be:
        i. Used to fund the payment?
        ii. If so, in full or in part?
        iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.
    e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?
    f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?
    g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?

8. Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:

    a) Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.
    b) Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?

c) Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years
d) If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.
e) Are there specific projects the additional funding will be used for?

9. Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:

a) Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.
b) What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?
c) What are the specific facility upgrades that are needed for $22 million?
d) What types of clinical equipment is going to be purchased for $18 million?
e) Explain the clinically integrated network development expenditure of $5 million.
f) Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.

10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.

11. Regarding the long term debt and the SMHS retirement plan, respond to the following:

a) Explain further the unfunded pension obligations including providing the current funded status of the plan.
b) Explain future plans to address the debt obligations including the rates being paid presently and the rates that would apply if the debt was refinanced.

12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?

13. What attempts were made to restructure debt under the current management structure?

14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.

15. Which entities are included in the NE-RHM financial worksheet data on page 441?

16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:

    a) List all hospitals THC has integrated into its system over the past three years.
    b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.

17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.

18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.

19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?

20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?

21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.

22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?

23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.

24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."

a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.
b) Indicate what services will likely be eliminated.

25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:

a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.
b) Other Operating Revenue remains the same in FYs 2016 – 2019.
c) There are no self-pay revenues provided in any of the years.
d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.

If you have any questions concerning this letter, please feel free to contact either me at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

Jessica Schaeffer-Helmecki
Jessica.schaeffer-helmecki@ct.gov
Planning Analyst

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Thursday, December 24, 2015 2:36 PM
To: Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
Subject: RE: Request for more information

I have received the e-mail.
Merry Christmas and Happy New Year.
Chris Hartley

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Thursday, December 24, 2015 2:32 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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From:	Attorney Bob Anthony
To:	"Hartley, Christopher"; Schaeffer-Helmecki, Jessica
Cc:	Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; "Rotavera, Liz"
Subject:	RE: Request for more information
Date:	Thursday, December 24, 2015 2:36:48 PM

I also received the email. Thank you. Happy holidays.

Bob Anthony

Sent with Good (www.good.com)

-----Original Message-----
From: Hartley, Christopher [CHartley@stfranciscare.org]
Sent: Thursday, December 24, 2015 02:35 PM Eastern Standard Time
To: Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
Subject: RE: Request for more information

I have received the e-mail.
Merry Christmas and Happy New Year.
Chris Hartley

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Thursday, December 24, 2015 2:32 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information

Mrrs. Hartley and Anthony:

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Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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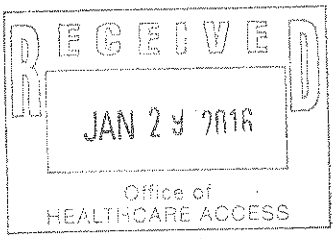
Saint Mary's HOSPITAL | Trinity Health New England

January 29, 2016

Via Hand Delivery



Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis Care, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find the original and CD containing our responses to OHCA's December 24, 2015 letter regarding the above referenced Certificate of Need application.

If you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: _____
Robert Anthony
General Counsel
Saint Mary's Health System

By: _____
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

Saint Mary's HOSPITAL | Trinity Health New England

January 29, 2016

Via Hand Delivery

Jessica Schaeffer-Helmecki
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R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

1. **What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.**

   The entity known as Saint Mary's Health System will be dissolved leaving Saint Mary's Hospital (Saint Mary's) as the surviving entity. The Trinity Health - New England entity will replace Saint Mary's Health System as the sole member of Saint Mary's Hospital. **Exhibit 24** reflects the proposed structure.

2. **Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.**

   Saint Mary's, along with Waterbury Hospital are both committed to ensuring that the services offered by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury continue to be offered to the greater Waterbury community. We will continue to work collaboratively and do understand that any changes that fall under the purview of the CON statutes will require both organizations to appropriately notify OHCA.

3. **Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.**

   Please see **Exhibit 25** (Saint Mary's Health System Amended and Restated Certificate of Incorporation) and **Exhibit 26** (Saint Mary's Health System Amended and Restated Bylaws).

4. **According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.**

   CON 07-31003 gave Connecticut Children's Medical Center the approvals to operate an Inpatient Pediatric Medical Surgical Unit on the Saint Mary's Hospital Campus. The neonatal ICU program, which existed before CCMC became involved with Saint Mary's Hospital, and continues to be a Saint Mary's Hospital program supporting the hospital's maternity program, and was not included in this ruling. Please see **Exhibit 27** for the Agreed Settlement. No other hospital's discharge data is included in the historical and projected data.

5. **What entity will be doing the billing for Saint Mary's if the CON is approved?**

   Saint Mary's Hospital will continue to bill as it currently does. There is no anticipated change in Saint Mary's current billing practices related to this proposal.

6. **Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.**

As noted in Section 4.01 Capital Commitment of the Transfer Agreement between Trinity Health /NE-RHM and Saint Mary's ("Transfer Agreement"), "Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than $120,000,000 subject to the achievement of the performance metrics in years four and five, to support operations of Saint Mary's and Saint Mary's controlled subsidiaries." This $100M capital commitment is part of the $275M capital commitment Trinity Health made to Saint Francis Care, Inc. as noted in CON #15-31979-CON. Trinity Health is responsible to ensure the $275M capital commitment to Saint Francis Care, Inc. (now the NE-RHM) and the NE-RHM is responsible to ensure $100M of this capital is allocated to Saint Mary's. Please see **Exhibit 28** for the documentation of the commitment.

7. With respect to the $100 million capital expenditure and two additional $10 million payments:

a) List all sources of funding and financing.

The sources of funding as agreed to in Section 4.01 of the Transfer Agreement are:

1. Available cash and investments generated by Saint Mary's;
2. Financing obtained through the Trinity Health system debt program; and, to the extent necessary,
3. Capital contributions from Trinity Health

The goal of the NE-RHM is for its subsidiaries to support their capital investments with their own cash flow. If Trinity Health, NE-RHM and Saint Mary's determine that financing the capital investments is more prudent than utilizing Saint Mary's cash generated from operations then the NE-RHM will access the Trinity Health debt program on behalf of Saint Mary's. For example, despite Saint Mary's generating sufficient cash flow for these expenditures, NE-RHM, Trinity Health and Saint Mary's may determine it is more prudent to maintain its current cash position and instead finance Saint Mary's capital investments. In this case, the NE-RHM, through Trinity Health, would provide financing to Saint Mary's for these capital investments.

b) What portion of the payment will be derived from Saint Mary's operational revenue?

The $100M of capital allocated to Saint Mary's is not a payment. It is a commitment to ensure an allocation of capital investment to Saint Mary's. The $100M of capital will be funded as noted in 7a above.

c) Is payment of the full $100 million amount contingent upon financial performance?

The allocation of $100M of capital investment is not contingent upon Saint Mary's financial performance.

d) Will Saint Mary's future income be:

i. Used to fund the payment?

Any of Saint Mary's cash flow can be used to pay for its capital expenditures as long as its use does not compromise Saint Mary's ability to fulfill its financial obligations.

ii. If so, in full or in part?

After review of the capital expenditure need and Saint Mary's balance sheet, it will be determined whether the capital expenditure will be funded by Saint Mary's cash flow partially or fully and, if only partially, the remainder of the capital expenditure will be financed using the Trinity Health debt program.

iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.

As noted in 7a above, if Saint Mary's cannot generate sufficient cash flow to fund a capital expenditure, the NE-RHM can obtain financing for the capital expenditure through the Trinity Health debt program.

e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?

As noted in paragraph 4.01 of **Exhibit 28**, only $20 million of the capital investment is contingent upon achieving financial performance metrics.

f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?

The allocation would be determined after the closing of the transaction in conjunction with NE-RHM based on Saint Mary's capital needs and the NE-RHM strategic and current priorities. NE-RHM will follow the Trinity Health system capital approval process, which will require NE-RHM approval for capital expenditures. Capital expenditures will also be subject to the Trinity Health governance matrix, which dependent on the level of a particular capital expenditure may require Trinity Health management or governance approval. Trinity Health management approval is typically for capital expenditures greater than $5M but less than $25M and capital expenditures greater than $25M require Trinity Health governance approval.

g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?

As deemed necessary by Trinity Health and NE-RHM, financing from Trinity Health System's debt program would be available to fund capital expenditures.

8. Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:

a) Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.

Payment is dependent upon the consolidated financial performance of Saint Mary's Hospital and its controlled subsidiaries achieving the operating cash flow margins as indicated in the Transfer Agreement.

b) Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?

This is the sole financial metric used as a condition for the additional $10 million of capital allocation in year 4 and additional $10M of capital allocation in year 5.

c) Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years

SMHS generated operating cash flow margin of 7.7%, 7.6% and 4.9% for FY13, FY14 and FY15, respectively. The Hospital generated standalone operating cash flow margins of 9.5%, 12.7% and 12.1% for FY13, FY14 and FY15, respectively.

d) If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.

As noted in the Transfer Agreement 4.01(b) and 4.01(c), respectively, $10M of additional capital commitment would be available in the 4th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 3rd year following the effective date and likewise, $10M of additional capital commitment would be available in the 5th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 4th year following the effective date. As an example, if the effective date of Saint Mary's joining Trinity Health/NE-RHM is 7/1/15, then if in the year ended 6/30/18 Saint Mary's and its controlled subsidiaries produce an operating cash flow margin of 8%, an additional $10M of capital will be allocated to Saint Mary's for the year ended 6/30/19.

e) Are there specific projects the additional funding will be used for?

There are currently none identified to date.

9. Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:

a) Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.

Yes, subject to approval by NE-RHM and/or Trinity Health. The projects have not yet been prioritized. That would happen after the transaction and in conjunction with the NE-RHM capital planning process.

b) What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?

Saint Mary's will continue to spend capital as needed for routine equipment replacement and routine facility upgrades. These routine expenditures are part of the $100M of capital commitment.

c) What are the specific facility upgrades that are needed for $22 million?

At this time, it is expected that Saint Mary's Hospital facility will require upgrades to its primary back-up generator, electrical power switching gear, along with planned replacements of two chillers and a series of area-specific air handling units. Additionally, three elevators are slated for replacement in addition to necessary nursing unit upgrades and modernization. Further, it is expected that the Holiday Inn will be demolished and replaced with an ambulatory pavilion.

d) What types of clinical equipment is going to be purchased for $18 million?

At this time, planned upgrades include two new fluoroscopy imaging units, a house-wide telemetry and patient monitoring upgrade, a real-time location tracking system for critical clinical equipment, operating room furnishing upgrades, upgraded breast imaging technology, and upgrades to support transition to single bed patient rooms.

e) Explain the clinically integrated network development expenditure of $5 million.

This is an estimate of certain IT costs to integrate providers for purposes of coordinating care management throughout our communities.

f) Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.

At this time, it is expected that the $10 million will be used to develop urgent care (and related services (e.g. diagnostic x-ray and lab draw) in the communities we serve. As an example, Saint Mary's has announced that it plans to build a new urgent care center, primary care office and physical therapy center in Naugatuck by 2017. Please see **Exhibit 29** for the announcement. Further, it is planned that a new pavilion ($25 million) may be developed on the hospital campus to provide ambulatory surgery (currently off campus) and other hospital services.

10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.

Trinity Health, NE-RHM and Saint Mary's are all committed to charity care consistent with their respective charitable missions and core values. Emergency medical care services are required to be provided to all patients who present to the emergency department, without regard to the patient's ability to pay. Trinity Health, NE-RHM and all RHMs provide financial support to medically indigent patients. Saint Mary's policies are consistent with both Trinity Health and the NE-RHM.

Trinity Health and its hospitals, including Saint Francis Hospital and Medical Center ("Saint Francis"), comply with the requirements of Internal Revenue Code Section 501(r) applicable to tax exempt hospitals. In FY 2016, additional requirements are effective and require hospitals to ensure their policies and procedures address items such as extraordinary collection efforts, notification requirements for presumptive eligibility, application periods and processing requirements, financial assistance documentation requirements and communication requirements (e.g., plain language).

Saint Mary's policy provided in the original CON at Exhibit S4 (page 696) is Saint Mary's current policy. In addition, Saint Francis current policy was provided in the original CON, Exhibit 20 page 494. No changes have been made to these policies since the original filing.

Once Saint Mary's joins NE-RHM, Saint Mary's staff will have access to the NE-RHM and the system office for advice and assistance in further implementing financial assistance opportunities for patients and ensuring compliance with these requirements.

11. Regarding the long term debt and the SMHS retirement plan, respond to the following:

a) Explain further the unfunded pension obligations including providing the current funded status of the plan.

The underfunded pension liability per the September 30, 2015 audited financial statements, which notes Saint Mary's estimated plan liabilities in excess of plan assets was $75.9M.

b) Explain future plans to address the debt obligations including the rates being

paid presently and the rates that would apply if the debt was refinanced.

There are no immediate plans to restructure Saint Mary's debt at closing. Additional analysis will be completed to determine if an intercompany loan will be used to pay-off or refinanced Saint Mary's current outstanding debt post-closing. Please reference response to Question 13 for the current debt rates.

12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?

Saint Mary's has not made any formal attempts to secure funding through bonds or loans from banking institutions for capital projects listed on page 82.

13. What attempts were made to restructure debt under the current management structure?

Saint Mary's refinanced its CHEFA debt in April 2015. Saint Mary's secured a $15 million bank loan and used approximately $5 million in debt service funds to call and extinguish the CHEFA Bonds. The Series E CHEFA Bonds ranged from 5-6% interest. The bank loan is for five years with $250k due in principal each month having an interest rate of LIBOR plus 110 basis points (approximately 1.5% total).

14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.

NE-RHM does not have a separate credit rating. The most recent credit ratings for Trinity Health are as follows:

- Moody's – Aa3, stable outlook, 12/21/15
- S&P – AA-, stable outlook, 12/23/15
- Fitch – AA, negative outlook, 12/30/15

15. Which entities are included in the NE-RHM financial worksheet data on page 441?

The entities included in the NE RHM are:
Saint Francis Care, Inc. (now known as Trinity Health- New England, Inc.)
Saint Francis Hospital and Medical Center, Inc. and Subsidiaries
Mount Sinai Rehabilitation Hospital
Saint Francis Hospital and Medical Center Foundation, Inc.
Saint Francis Medical Group, Inc. and Subsidiary
Asylum Hill Family Medicine, Inc.

16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:

a) List all hospitals THC has integrated into its system over the past three years.

Please see response in Question 16b below.

b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.

Trinity Health's most recent system-level merger with Catholic Health East leveraged the capabilities and expertise of both organizations. The resulting scope and scale has yielded more than $285 million of synergies since the Catholic Health East/Trinity Health consolidation in May 2013, with more than $25 million additional synergies planned through the fiscal year ended June 30, 2016. Actual and forecasted synergies are through initiatives such as renegotiating national vendor contracts, centralizing data center operations, combining our two insurance captives, reducing third party administrator fees, insourcing work related to compliance, internal audit and tax, and through growth and standardization initiatives. Trinity Health reported operating expenses of $13.9B in FY 2015, therefore realizing synergies savings of 1.8% of operating expenses.

Savings have also been realized in other significant Trinity Health acquisitions of local health systems and hospitals:

St. Joseph Health, Inc. ("SJH") is located in Syracuse New York– Effective date 7/1/15 – SJH has only been part of Trinity Health for a short period of time but over the last six months, SJH has realized approximately $4M of savings related to integrating SJH into Trinity Health insurance programs (combined brokers, reduction of duplicate administrative costs, etc.), reducing supply expense and lowering the cost of debt service. Additionally, joining the Trinity Health debt program has also created benefits such as less administrative burden related to debt financing for local SJH management and eliminating debt issuance timing risk (the risk of accessing the debt market in a high rate environment). This $4M savings as a percentage of SJH $700M of annual operating expense is 0.6%.

Saint Francis Care, Inc. (SFC) – Effective date 10/1/15 – SFC has only been part of Trinity Health for one quarter. See response to 18 below for some opportunities anticipated to be realized.

17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.

Since this proposed transaction is still in the pre-approval stage, the type of information and analysis that is able to be performed is limited and, therefore, prevents the organizations from getting into specifics with respect to future savings. The areas identified in original CON are those areas where Trinity Health hospitals have historically realized benefits post close. Based on historical savings achieved by other

health systems after joining Trinity Health (refer to response to #16 above), the organizations anticipate achieving a 1% reduction in consolidated SMHS operating expenses by year two post-close. As noted in the response to #18 below, Saint Francis expects to achieve similar savings once efforts are fully implemented.

18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.

Saint Francis has only been part of Trinity Health for one quarter and the identification of cost savings and other opportunities is ongoing. Based on initial analysis preformed to date, we anticipate starting to realize savings over the next eighteen months and the annual impact of these items is approximately:

- $4.0 million in annual savings relating to utilizing Trinity's group purchasing organization
- $2.0 million in software costs
- $760,000 interest expense
- $600,000 depreciation expense
- $300,000 in revenue cycle costs

Total annualized savings upon implementation of these efforts are $7,660,000, approximately 1% of Saint Francis operating expenses. Saint Francis also anticipates that it will save approximately $3.0 million in capital costs over the next two years due to better pricing under Trinity contracts. This reduced capital expense will result in a reduction in annual depreciation expense as noted above.

In addition to the above synergies, as of October 1, 2015, Saint Francis Hospital and Medical Center defeased $246 million in outstanding CHEFA bonds utilizing proceeds from an intercompany loan from Trinity Health. In addition, a fixed pay interest rate swap was transferred to Trinity Health. This transfer resulted in a $44 million reduction of Saint Francis' liability related to the interest rate swap, which strengthened Saint Francis' balance sheet by increasing its unrestricted net assets. Furthermore, the results of the debt refinancing with the intercompany loan, resulted in a reduction in interest expense as well as eliminated future interest rate risks.

19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?

Saint Mary's will benefit from being part of the broader NE-RHM and its contracts. Cost reductions from NE-RHM contracts are expected for items such as medical supplies, blood products, information technology and management contracts as a result of being part of a much larger healthcare system.

20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?

These amounts have not been included in the financial projections. Shared system office services include Revenue Excellence, Treasury, Human Resources, Supply Chain Management and Information Technology. These shared services are charged to Saint Mary's by the NE-RHM using an appropriate metric once an organization begins to access the benefits of these system departments. The NE-RHM will be charged for its share of these services and the NE-RHM will determine appropriate allocation, if any, to the entities within the RHM.

21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.

Physician partnerships are contributing reason for the proposal as Saint Mary's strives to grow its physician enterprise. Over the past year and a half, Saint Mary's has formed Valley Health Alliance, an accountable care organization that has recently started working on shared savings program with Medicare. In addition, the ACO has begun a program with Anthem for those patients that are employees of Saint Mary's. This type of physician partnership requires additional management, staffing, data analysis and clinical oversight; areas where Saint Mary's needs more support. This is especially true as the number of physician partners continues to grow and as the shared savings programs are implemented. Saint Mary's could use the additional resources offered by NE-RHM whose physician enterprise is more equipped to handle these physician partnerships.

22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?

Saint Francis Hospital and Medical Center (Saint Francis), which is part of the NE-RHM, provides market leading Cancer, Joint Replacement and Cardiology services. Saint Francis's Cancer program is affiliated with Yale New Haven Health's Smilow Cancer Hospital, a premier research and treatment cancer institute. This proposal will allow for Saint Mary's to have better access to ground breaking clinical trials, provide broader screening and diagnostic tools, access to additional treatment options, increased psychosocial support and improved pain management therapies. Along with the high quality Radiation Therapy provided by the Harold Leever Cancer Center, patients in the Greater Waterbury area will benefit from this proposal. Saint Francis's Connecticut Joint Replacement Institute ("CJRI") is nationally recognized as a pioneer in reducing costs, improving quality and improving the patient experience. Saint Mary's collaboration with Saint Francis at adopting these advanced techniques can only stand to improve the joint replacement care in the Greater Waterbury market. Saint Mary's will benefit from the collaboration with Saint Francis's Hoffman Heart Institute. With one of the largest heart bypass and cardiac catheterization programs in the region, along with the national recognition from both the American Heart Association and American College of Cardiology, Saint Mary's will be able to adopt many of the techniques that made the institute nationally recognized. Trinity Health, with its 86 hospitals, will also provide the potential to learn and adopt best practices from hospitals leading the nation in these three services.

23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.

Currently Saint Mary's utilizes the McKesson Paragon EHR. While an adequate industry EHR, the NE-RHM's EPIC EHR system more seamlessly integrates inpatient, ambulatory and physician electronic medical information.

24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."

Costs reduction will be obtained from adopting best practices such as those exhibited by Saint Francis's CJRI program. CJRI has been able to reduce complication rates, reduce hospital length of stays, reduce pain and allow for a quicker recovery time so that patients may return to full function sooner. As Saint Mary's collaborates with NE-RHM, processes can be streamlined and others may be enhanced. Some examples may include medical supply purchase processes, provider recruitment, clinical program enhancements, clinical service benchmarking, call coverage contracts and medical equipment purchasing. In no manner does an elimination of duplicative services refer to clinical programs, rather it refers to the operational management of these services.

The language on page 85 is associated with the Lean Management approach. NE-RHM employs this organizational efficiency and quality approach, most notably associated with the Toyota Production System Manufacturing to many of its processes. A key component of this Lean Management approach is to focus on standardization of work to eliminate duplicative steps and thereby eliminate waste. A similar process is associated at UTC's through its Ito University. Once Saint Mary's becomes part of NE-RHM, many of its clinical protocols will be compared to those used by the NE-RHM. NE-RHM will standardize the way care is delivered at each clinical service site where possible. (A sample project illustrates the kind of standardization and reducing variations in care initiative that Trinity Health would engage in as part of this synergy. Reducing the wastage and unnecessary use of blood products (such as blood transfusions) not only is a process and resource drain but also poses health risks to patients from unnecessary transfusions. Trinity Health has a standardized process and protocol around when and how to use blood products. Implementation of this protocol would result in improved care, less waste and better health of our patients.)

There are no plans to eliminate any clinical services at Saint Mary's as a result of this application. However, an efficiency analysis, as noted above, will be completed for each clinical area once Saint Mary's has joined Trinity Health-New England.

This effort is time consuming and different for each clinical service. No timeline has been established for this work and a plan and related timeline will not be developed until after SMHS is officially part of NE-RHM.

a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.

See the answer to Question 24 above.

b) Indicate what services will likely be eliminated.

See the answer to Question 24 above.

25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:

a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.

Other Deductions includes the net position of the Hospital Provider Tax offset by expected supplemental payments. At the time of our original assumptions, the State reduced all supplemental payments for SFY16. We assumed supplemental payments would resume in SFY 17, which is the 4th quarter of our FY16. Therefore, the estimated net tax position increased to $9.7M for FY16. We assumed no change in supplemental payment or hospital tax base in FY17-FY19.

b) Other Operating Revenue remains the same in FYs 2016 – 2019.

Other Operating Revenue assumptions include decreases in Meaningful Use from Medicare and Medicaid which is offset by increases in other areas such as Cafeteria, Rent, Child Care, Grants and Net Assets Released From Restriction.

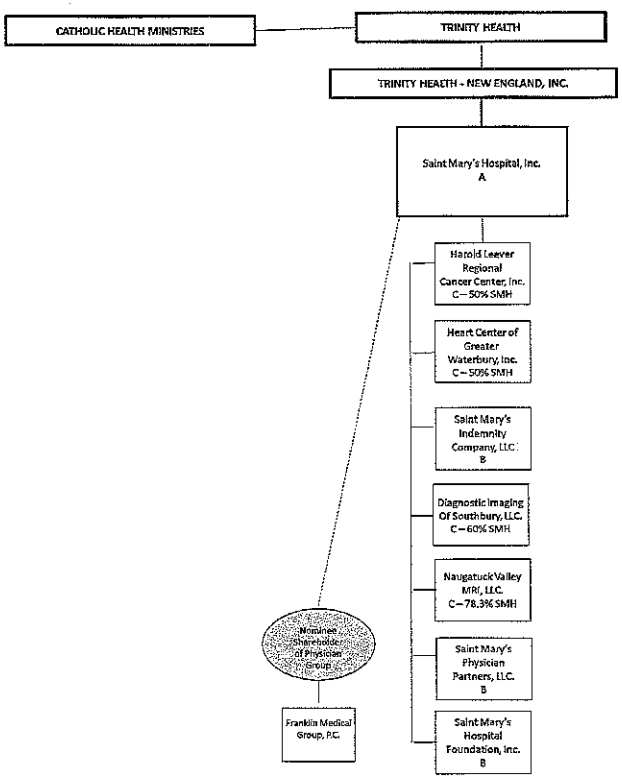
c) There are no self-pay revenues provided in any of the years.

See updated projections **Exhibit 30**. The net revenue by payor percentage was originally spread based on actual cash collections, however, bad debt expense should have been factored in, as the formula in the spread sheet is before bad debts. We note that self-pay net revenues are included in the uninsured category.

d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.

Saint Mary's refinanced its CHEFA debt in April 2015 saving approximately $1.0 million annually in interest costs. See response to Question 13 for further details.

EXHIBIT 24



A Direct Subsidiaries of THNE
B Direct Subsidiaries of A entities
C Shared entities – reflecting the ownership Percentages of SMH

EXHIBIT 25

Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Saint Mary's Hospital, Inc.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III

Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV

Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common

Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

ARTICLE VIII

Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with

such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

EXHIBIT 26

BYLAWS

OF

SAINT MARY'S HOSPITAL, INC.

A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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Article I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

(i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or

(ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

Article II. PURPOSES

Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

Article III. MEMBER

Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

Section 3.02 Member Authority

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the

Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

Section 3.03 Reserved Powers of Trinity Health

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

Section 3.04 Meetings of the Member

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

Article IV. BOARD OF DIRECTORS

Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation

(who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

Section 4.03 Term

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

Section 4.04 Annual Meeting of the Board of Directors

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

Section 4.05 Regular Meetings and Notice

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

Section 4.06 Special Meetings and Notice

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

Section 4.07 Waiver of Notice

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

Section 4.08 Quorum and Valid Director Action

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

Section 4.09 Written Consents

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

Section 4.10 Communication Equipment

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 4.11 Resignation

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

Section 4.12 Removal

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

Section 4.13 Periodic Performance Review

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

Article V. MEDICAL/DENTAL STAFF

Section 5.01 Medical/Dental Staff Bylaws

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

Section 5.02 Medical/Dental Staff of Operating Units

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

Article VI. COMMITTEES

Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective committees through the next annual meeting or until their successors are

appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

Section 6.04 Quorum, Meetings, Rules and Procedures

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

Section 6.05 Committee Composition

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

Article VII. OFFICERS

Section 7.01 Officers

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time. Officers shall hold their respective offices until their successors are chosen and qualified.

Section 7.02 Appointment and Election of Officers

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The Chair shall serve a term of one (1) year and may be elected for a total of three (3)

consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

Section 7.03 Vacancies

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

Section 7.04 Chair

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

Section 7.05 President

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

Section 7.06 Secretary

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

Section 7.07 Treasurer

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

Article VIII. INDEMNIFICATION AND STANDARD OF CARE

Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 8.04 Justifiable Reliance

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 8.05 Consideration of Factors

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 8.06 Presumption

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

Section 8.07 Personal Liability of Directors

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

Article IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

Article X. OPERATING UNITS

Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

Article XI. MISCELLANEOUS

Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

Section 11.03 Confidentiality

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

Section 11.04 Conflict of Interest

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

Article XII. AMENDMENT AND REVIEW

Section 12.01 Amendment

These Bylaws may be amended only in accordance with Article III of these Bylaws.

Section 12.02 Periodic Review

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

EXHIBIT 27

Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants: Connecticut Children's Medical Center
Saint Mary's Hospital Corporation
Waterbury Hospital

Docket Number: 07-31003-CON

Project Title: Termination of Inpatient Pediatric Services at Saint Mary's Hospital and Waterbury Hospital and the Establishment and Operation of New Inpatient Pediatric Services at Saint Mary's Hospital by Connecticut Children's Medical Center

Statutory Reference: Section 19a-638, C.G.S.

Filing Date: January 23, 2008

Hearing Date: February 20, 2008

Presiding Officer: Cristine A. Vogel, Commissioner

Decision Date: May 1, 2008

Default Date: May 22, 2008 (30-day extension)

Project Description: Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH") propose to terminate inpatient pediatric services and Connecticut Children's Medical Center ("CCMC") proposes to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility at an estimated total capital expenditure of $600,079.

Nature of Proceedings: On January 23, 2008, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH"), proposing to terminate inpatient

pediatric services, and Connecticut Children's Medical Center ("CCMC"), proposing to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility, at an estimated total capital expenditure of $600,079. CCMC, SMH and WH are health care facilities or institutions as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on February 20, 2008. On February 5, 2008, the Applicants were notified of the date, time, and place of the hearing. On February 2, 2008, a notice to the public announcing the hearing was published in *The Waterbury Republican-American.* Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact of the Proposal on the Applicants' Current Utilization Statistics
Proposal's Contribution to the Quality of Health Care Delivery in the Region
Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford, Connecticut. It is licensed at 103 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 19)*

2. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. It is licensed at 347 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 17)*

3. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. It is licensed at 357 beds and 36 bassinets. *(July 13, 2007, Letter of Intent, page 18)*

4. SMH and WH propose to terminate their inpatient pediatric services. CCMC proposes to establish, own, and operate new inpatient pediatric services within SMH. *(December 13, 2007, Initial CON Submission, page 2)*

5. CCMC will seek to have an additional satellite inpatient location, with 12 additional licensed medical/surgical beds, added to its existing Children's Hospital license issued by the State of Connecticut Department of Public Health. *(December 13, 2007, Initial CON Submission, pages 8 and 10)*

6. The following towns are within the service area of SMH and WH and account for over 90% of the pediatric admissions of the two hospitals in FY 2005, 2006, and 2007:

Table 1: Towns within the Service Areas for SMH and WH

Beacon Falls	Bethlehem	Cheshire	Middlebury	Morris
Naugatuck	Prospect	Southbury	Thomaston	Waterbury
	Watertown	Woodbury	Wolcott	

(December 13, 2007, Initial CON Submission, page 2)

7. The population to be served includes the 56,746 children between birth and 18 years of age in the service area towns based upon the 2000 census; 24,252 of them reside in the city of Waterbury. *(December 13, 2007, Initial CON Submission, page 3)*

8. SMH currently staffs 209 of its 347 licensed beds, 12 are in the pediatric unit. WH currently staffs 265 of its 357 licensed beds, 10 are in the pediatric unit. *(December 13, 2007, Initial CON Submission, page 4)*

9. According to the Applicants, all pediatric inpatients will be admitted to the CCMC inpatient pediatric unit located within SMH. SMH and WH will no longer have pediatric inpatients as part of their patient volumes. The pediatric providers and support staff will be part of CCMC. CCMC pediatric medical and surgical specialists will be available for consultations as needed. *(December 13, 2007, Initial CON Submission, page 4)*

10. The following table reports the respective hospital's market share percentage for each town within the service area:

Table 2: Market Share Analysis by Town and Hospital

	Market Share Percentage by Hospital					
Town	**CCMC**	**SMH**	**WH**	**Yale-NH**	**Others**	**Town Total**
Beacon Falls	0.5%	13.0%	17.7%	11.1%	42.2%	100%
Bethlehem	0.0%	15.5%	56.0%	2.9%	74.4%	100%
Cheshire	0.8%	10.8%	6.8%	23.9%	42.4%	100%
Middlebury	0.7%	20.9%	53.9%	7.1%	82.7%	100%
Morris	0.2%	9.4%	24.5%	4.5%	38.5%	100%
Naugatuck	0.7%	33.5%	40.5%	6.1%	80.8%	100%
Prospect	1.3%	40.4%	34.8%	8.4%	84.9%	100%
Southbury	0.3%	8.0%	35.2%	4.5%	48.0%	100%
Thomaston	1.0%	16.9%	47.1%	3.7%	68.8%	100%
Waterbury	0.7%	45.5%	42.3%	3.8%	92.3%	100%
Watertown	0.9%	21.3%	62.8%	4.0%	89.0%	100%
Woodbury	1.1%	45.0%	29.8%	3.6%	79.5%	100%
Wolcott	0.6%	12.8%	47.6%	6.0%	66.9%	100%

Source: OHCA Hospital Inpatient Discharge Database FY 2007.

11. The units of service for the past three fiscal years by service area town for each hospital for children ages 0 to 18, excluding newborns, are reported in the following three tables:

Table 3a: Service Utilization by Fiscal Year for CCMC

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007***
Beacon Falls	2	5	1	2
Bethlehem	2	0	0	4
Cheshire	16	21	18	17
Middlebury	5	4	7	2
Morris	0	0	0	1
Naugatuck	28	31	17	30
Prospect	7	6	17	16
Southbury	5	6	10	5
Thomaston	9	8	9	6
Waterbury	108	119	96	126
Watertown	29	24	16	32
Woodbury	10	5	5	6
Wolcott	31	27	16	14
Total for Service Area	**252**	**256**	**212**	**261**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

Table 3b: Service Utilization by Fiscal Year for SMH

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007***
Beacon Falls	3	6	3	1
Bethlehem	1	2	1	1
Cheshire	5	6	4	10
Middlebury	11	11	8	8
Morris	1	3	0	0
Naugatuck	59	47	56	65
Prospect	23	13	6	22
Southbury	5	3	5	5
Thomaston	6	3	10	4
Waterbury	519	511	503	511
Watertown	30	28	21	35
Woodbury	8	7	4	11
Wolcott	20	24	21	36
Total for Service Area	**691**	**664**	**642**	**709**
Other Towns	33	53	48	-
Grand Total	**724**	**717**	**690**	**-**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

Table 3c: Service Utilization by Fiscal Year for WH

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007**
Beacon Falls	4	2	3	4
Bethlehem	5	5	3	1
Cheshire	4	2	2	2
Middlebury	14	5	13	11
Morris	1	2	1	0
Naugatuck	64	62	42	42
Prospect	6	13	6	6
Southbury	12	4	8	6
Thomaston	15	24	9	10
Waterbury	284	265	237	226
Watertown	49	51	33	38
Woodbury	12	13	14	12
Wolcott	16	18	21	20
Total for Service Area	**486**	**466**	**392**	**378**
Other Towns	53	32	28	-
Grand Total	**539**	**498**	**420**	**-**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

12. The following table reports the number of children under age 18, excluding newborns, who were treated at the SMH emergency department ("ED") or the WH ED:

Table 4: Number of Children Treated in SMH ED and WH ED

Facility	Category	FY 2005	FY 2006	FY 2007
Saint Mary's Hospital	Treated and Discharged	15,098	15,881	15,855
	Treated and Admitted	586	554	575
	Total	15,684	16,435	16,430
Waterbury Hospital	Treated and Discharged	10,225	9,685	9,157
	Treated and Admitted	348	384	385
	Total	10,573	10,069	9,542

Source: ChimeData ED Data, FY 2005 to FY 2007

13. The following table reports the bed occupancy of the pediatric units at SMH and WH by bed days:

Table 5: Bed Occupancy by Hospital and Fiscal Year

	SMH			WH		
	Fiscal Year			Fiscal Year		
	2005	2006	2007*	2005	2006	2007*
Number of Pediatric Beds	12	12	12	10	10	10
Maximum Number of Bed Days per Year	4,380	4,380	4,380	3,650	3,650	3,650
Pediatric Discharges	717	690	741	498	420	491
Average Length of Stay	2	2	2	2	2	2
Number of Pediatric Bed Days	1,434	1,380	1,482	996	840	982
Bed Occupancy, %^	32.7%	31.5%	33.8%	27.3%	23.0%	26.9%

* Source of FY 2007 pediatric discharges: OHCA Hospital Inpatient Discharge Database.
^ (Pediatric bed days/Maximum number of bed days per year) * 100.
(January 23, 2008, Completeness Submission, page 2)

14. The following table reports the number of projected admissions at the proposed CCMC pediatric inpatient unit, and the projected number of total inpatient days:

Table 6: Projected Volume

	FY 2008 *	FY 2009	FY 2010
Admissions	276	1,100	1,133
Total Inpatient Days	550	2,200	2,266

*Last quarter of 2008 only.
Note: These calculations are based upon a moving average of total pediatric inpatient admissions at WH and SMH for FY 2005 to FY 2007. CCMC is projecting 3% growth in FY 2010. The projected average length of stay is 2.0 days, the weighted average current length of stay for WH and SMH.
(December 13, 2007, Initial CON Submission, page 4)

15. CCMC is proposing a 12-bed unit, based on the following factors:
    - 1,100 pediatric admissions with an average length of stay of 2.0 days;
    - An average daily census for SMH and WH of 6.03 patients;
    - An estimated peak of 10.6 patients and a low 4.5 patients; and
    - Seasonal variations and additional bed flexibility for patients who stay less than 24 hours and are not reported in the daily census.

    (January 23, 2008, Completeness Submission, pages 1 and 2)

16. CCMC currently meets the guidelines of the American Academy of Pediatrics Committee on Hospital Care for facilities and equipment and for staffing patterns for patient care and support personnel at its main campus in Hartford. CCMC plans to meet these guidelines at the new satellite unit in Waterbury. *(December 13, 2007, Initial CON Submission, page 4)*

17. The Memorandum of Understanding concerning pediatric care in the Waterbury area has the following provisions:
    - CCMC will create a single community-wide pediatric program;
    - CCMC will own, operate and supervise an inpatient pediatric medical/surgical services unit located on the campus of SMH;
    - CCMC shall contract for space, equipment and support services from SMH as needed;
    - Initial contract is for five years, with automatic five year renewals;
    - Termination of contract requires 12 months notification;
    - SMH and WH Emergency Departments will continue to treat children;
    - SMH and WH will continue to provide children's outpatient services; CCMC will provide clinical leadership and enhanced training opportunities for clinical staff at both SMH and WH; and
    - CCMC shall provide all services and operate its program in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

    (December 27, 2007, Memorandum of Understanding dated December 19, 2007)

18. Patients will be admitted to the new pediatric inpatient unit either by their community physician or from transfer from the SMH's ED or WH's ED. *(March 19, 2008, Response to Additional Late File Request, page 2)*

19. For pediatric patients who have received a disposition from WH that an inpatient admission is required, transportation to the admitting hospital will be by ambulance. No transportation will be provided by parents or guardians. *(March 19, 2008, Additional Late File Request Response, page 2)*

20. The attending physician at the referring hospital is responsible for "medical control" until the patient arrives at the receiving hospital. The ambulance company will be the responsible party until care is transferred to the staff of the receiving hospital. *(March 19, 2008, Additional Late File Request Response, page 2)*

21. In FY 2006, WH had 420 pediatric inpatients, of whom 340 (81%) were admitted through its ED. It is estimated that 324 will be the approximate number of patients that may be transported to SMH for admission to the CCMC pediatric inpatient unit. *(March 19, 2008, Additional Late File Request Response, page 3)*

22. The majority of patients at the CCMC pediatric inpatient unit will be admitted by physicians from the Waterbury community who elect to have CCMC privileges. CCMC medical staff will oversee the care provided at the proposed pediatric inpatient unit to assist the physicians of record in day-to-day care of those patients. CCMC medical staff will include a full time medical director and mid-level practitioners, a combination of APRNs and physician assistants who will work under the direct supervision of that physician. Specialists on the CCMC medical staff, members of the CCMC Faculty Practice Plan or other CCMC-associated practices will be available on a consultative basis, at the request of the attending physician. If a patient requires ongoing specialty care they will likely be initially

admitted to CCMC in Hartford or will be transferred to that facility. *(January 23, 2008, Completeness Submission, page 2 and February 20, 2008, Hearing Testimony of Leonard Banco)*

23. The proposal will enhance the ability to recruit and retain pediatric staff through the integration with the staff of a children's hospital. CCMC has infrastructure for the education and training of pediatric healthcare professionals, including nursing and medical professional and post-graduate education programs that will support the consolidated department in Waterbury. This proposal will provide increased opportunities for recruitment of staff with pediatric skills and maintenance of their competency, and will allow pediatric staff to rotate between secondary and tertiary environments of care to enhance clinical education and maintenance of skills. *(December 13, 2007, Initial CON Submission, pages 4, 8, &17 and February 20, 2008, Hearing Testimony of Robert Ritz)*

24. Surgeons are less likely to have privileges at both hospitals, rather admitting to one or the other most of the time. Surgical patients below the age of 18, mostly ortho-pedic or general surgery patients, comprise a small percentage of patients admitted to the pediatric inpatient units. *(December 13, 2007, Initial CON Submission, page 9)*

25. The following conditions are frequently the reasons for pediatric inpatient admissions to SMH and WH:
    - Appendectomy;
    - Bronchitis, asthma, pneumonia, or pleurisy;
    - Cellulitis;
    - Concussion;
    - Diabetes;
    - Digestive disorders;
    - Kidney and urinary tract infections; and
    - Nutritional and miscellaneous metabolic disorders.

    Source: OHCA Hospital Inpatient Discharge Database 2005 to 2007.

26. With respect to CCMC, most referrals from the proposal's service area have been made by community pediatricians or family practitioners to pediatric medical and surgical sub-specialists who then admit them to CCMC. Additionally, a smaller number of admissions have been the result of inter-hospital transfers made by WH and SMH to CCMC. *(December 13, 2007, Initial CON Submission, page 9)*

27. The transfer policy concerning patients that require admission from the WH ED to the CCMC pediatric inpatient unit at SMH or another in-patient facility includes the following provisions:
    - The ED physician at WH will contact the accepting inpatient physician and arrange a bed transfer upon agreement that the patient's condition is appropriate for the level of care;
    - WH ED nursing staff communicate the nursing report to the receiving inpatient nursing staff;
    - Standard transfer documents and copies of patient care documentation and diagnostic studies are sent with the patient or faxed to the inpatient unit;

- Arrangements are made by the WH ED for appropriate levels of ambulance transport services;
- WH ED will serve as medical control during the transfer;
- Patients will be brought directly to the CCMC unit via the SMH ED entrance;
- The patient's caregiver or family will be informed of transfer arrangements and if permissible may accompany patient in the ambulance.

(March 19, 2008, Additional Late File Request Response, Attachment 3)

28. Follow-up outpatient care for patients discharged from the CCMC pediatric inpatient unit will be arranged by the patient's attending physician of record or designee. *(January 23, 2008, Completeness Response, page 5)*

29. As part of the transfer and admission process from WH's ED, SMH's ED and private physicians' offices, all patients will be informed about the new CCMC pediatric inpatient unit. The general public will be informed about the unit through a communications plan including press releases, paid advertisements, the public web sites of all three hospitals, and external signage at the hospitals. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

30. The draft communications plan indicates that press releases and paid advertisements to the general public will communicate that the CCMC pediatric inpatient unit at SMH will provide services in accordance with the Ethical and Religious Directives for Catholic Health Care Services, and that patients who prefer to be treated in a non-denominational environment will be transferred to CCMC in Hartford or another facility as directed by their attending physician. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

31. CCMC and SMH will have a Master Service Agreement where, on an exclusive basis, all of CCMC's needs for services shall be provided by SMH. SMH will provide the following services to the CCMC pediatric inpatient unit:
    - Perioperative;
    - Imaging;
    - Diagnostic Laboratory;
    - Pharmacy;
    - Pulmonary and Respiratory Therapies;
    - Supplies, any and all without limitation; and
    - Rehabilitative.

    (March 19, 2008, Late File 1)

32. The lease between SMH and CCMC has a five year term with two successive renewal options of five years each. The lease includes, but is not limited to, the following services:
    - Maintenance and repair;
    - Security;
    - Laundry and housekeeping;
    - Telecommunications; and
    - Occupational and Social.

    (March 19, 2008, Late File 1)

33. The following table summarizes the changes in staffed, licensed, and pediatric inpatient beds for each of the three hospitals:

Table 7: Summary of Changes to Staffed, Licensed, and Pediatric Patient Beds

Hospital	Bed Description	Existing Licensed/ Staffed	Proposed Increase or (Decrease)	Proposed Licensed/ Staffed
CCMC	Total	135/127	12	147/139
	Pediatric Medical/Surgical	103/92	12	115/104
SMH	Total	347/209	3 staffed adult	347/200
	Pediatric Medical/Surgical	12	(12)*	0/0
WH	Total	357/246	0	357/246
	Pediatric Medical/Surgical	10	(10)**	0/0

*Existing 12-bed unit will become the new CCMC owned and operated pediatric unit; SMH will add 3 staffed adult medical/surgical beds.

**Existing 10-bed unit will be used for adult medical/surgical beds.

(December 13, 2007, Initial CON Submission, page 10 and January 23, 2008, Completeness Response, page 3)

34. Martin Gavin, President, CCMC, testified at the hearing that:
    - The strategic mission of CCMC since its inception in 1996 has been to bring the highest level of pediatric care to as many children as possible;
    - Two years ago local pediatricians approached SMH and WH to consider the consolidation of the two inpatient pediatric units into a single unit;
    - For the past two years leaders from CCMC and the two hospitals have met regularly to investigate the best means to deliver pediatric inpatient care; and
    - For children that come to Hartford and do not have insurance CCMC makes every attempt to enroll them in the HUSKY program.

    (February 20, 2008, Hearing Testimony of Martin Gavin)

35. Gerald Boisvert, the Chief Financial Office for CCMC, stated at the hearing, "If necessary, CCMC would absorb the cost of the ambulance ride from WH's ED to SMH to be admitted to the new satellite unit." *(February 20, 2008, Hearing Testimony Gerald Boisvert)*

36. Bob Ritz, President and CEO of SMH testified that:
    - The three organizations have considered how to improve the access and quality of inpatient pediatric services in the greater Waterbury community;
    - The proposal is unique as WH and SMH are looking for ways to consolidate services to eliminate costly overhead duplication to improve each hospital's the long-term financial outlook;
    - The proposal will provide opportunities for professionals to train and obtain clinical experiences; and
    - The proposal is responsive to the State of CT's request to look for ways to collaborate with WH.

    (February 20, 2008, Hearing Testimony of Bob Ritz)

37. John Tobin, CEO of WH, stated at the hearing that if the proposal were implemented and then terminated, SMH and WH would resume providing the services, perhaps by continuing the same unit under SMH rather than splitting it out to two units. *(February 20, 2008, Hearing Testimony of John Tobin)*

38. Sandra Roosa, SMH, testified that currently WH has more psychiatric services for children than SMH. SMH does receive children requiring psychiatric services in its ED. It is the hospitals' belief that parents will continue to utilize the ED at the hospital of their choice. *(February 20, 2008, Hearing Testimony of Sandra Roosa)*

39. Leonard Banco, MD, CCMC's consultant for the proposal, testified that:
    - The children currently being admitted to SMH and WH are the secondary level inpatients requiring treatment for conditions such as asthma, dehydration, and minor trauma;
    - Most of the patients requiring care by sub-specialists are no longer admitted to SMH or WH, but are generally cared for by CCMC or by Yale-New Haven Hospital. The referring physician and the admitting physician decide where a child needs to be admitted based on the level of expertise required or the severity of the condition and the care that the patient will need; and
    - The CARES[1] unit at CCMC will consider making the Waterbury area the site of its next location for a CARES model program to address the needs of children with psychiatric needs.

    (February 20, 2008, Hearing Testimony of Dr. Leonard Banco)

40. Steven Schneider, MD, testified for WH that Medicaid currently pays for ambulance transportation for patients. *(February 20, 2008, Hearing Testimony of Steven Schneider)*

[1] The CARES (Children and Adolescent Rapid Emergency Services) program is a short-term care unit located within Hartford Hospital's Institute of Living under collaboration with CCMC that provides care for children and adolescents who are in psychiatric crisis with intensive psychiatric assessment, stabilization, and case management in order to link the child to community services.

Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Applicants' Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

41. The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. The components of the capital expenditure are given in the following table:

Table 8: Major Cost Components/Total Capital Expenditure

Medical Equipment (Purchase)	$	$100,000
Non-Medical Equipment (Purchase)*		$100,079
Construction/Renovation		$400,000
Total Capital Expenditure	**$**	**$600,079**

* Includes items such as beds, cribs, carts, appliances, and other patient room furniture and equipment.
(December 13, 2007, Initial CON Submission, pages 12 and 14)

42. The renovation costs include the creation of more rooms with single beds, so that parents can room-in. The inpatient area will receive a complete finish renovation. The current floor, wall and ceiling materials at SMH are worn and dated, and require replacement. The proposed renovations will be undertaken primarily to create a pediatric-friendly environment that emulates the appearance of CCMC's main campus in Hartford and bring the facility up to CCMC infection control standards. *(December 13, 2007, Initial CON Submission, page 13)*

43. CCMC has set a target date of June 1, 2008 to obtain State of Connecticut Department of Public Health license and plans to begin operations in July 2008. *(December 13, 2007, Initial CON Submission, page 14)*

44. Financial stability will essentially be unchanged for SMH and WH. Both hospitals will no longer employ dedicated pediatric providers or support staff for their former inpatient pediatric units which will partially offset the loss of revenue. *(December 13, 2007, Initial CON Submission, pages 4 and 19)*

45. CCMC will be billing for the proposed services. CCMC will pay SMH for services provided under the Master Service Agreement. CCMC will add a new cost center, "Waterbury Med/Surg." *(December 13, 2007, Initial CON Submission, pages 10-11 and March 19, 2008, Late File 1)*

46. WH's cost center, "Pediatrics" #9100-00, will be terminated. SMH's cost centers, "Pediatrics" #3040 and "Sacred Heart 4" #3085 will be terminated. *(December 13, 2007, Initial CON Submission, pages 4 and 11)*

47. The incremental revenues, expenses, and gain or loss from operations projected for the next three years for each hospital are reported in the following three tables:

Table 9a: Projected Incremental Revenues, Expenses, and Gain from Operations for CCMC

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue	Non-Government	$ 778,465	$3,431,772	$3,894,919
	Medicaid	678,975	2,715,900	2,797,377
Total Net Patient Revenue		**1,457,440**	**6,147,672**	**6,692,296**
Operating Expenses (variable)	Salaries	374,969	1,499,874	1,567,369
	Professional	125,000	500,000	522,500
	Supplies and Drugs	247,665	990,659	1,015,425
	Bad Debts	33,866	142,851	155,506
	Other Oper. Expenses	3,000	412,000	412,300
Operating Expenses (fixed)	Depreciation	30,000	60,000	60,000
	Interest	0	0	0
	Lease	358,750	1,435,000	1,435,000
Total Operating Expense		1,173,249	5,040,384	5,168,100
Gain from Operations		**$ 284,191**	**$1,107,288**	**$1,524,196**
FTEs		**5**	**20**	**20**
Inpatient Days		**550**	**2,200**	**2,266**

* Applicants expect that unmet demand will utilize the new CCMC pediatric inpatient unit and be similar to the growth rate at CCMC-Hartford.

(March 19, 2008, Late File 3, Exhibit 1)

Table 9b: Projected Incremental Revenues, Expenses, and Loss from Operations for SMH

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue	Non-Government	$(312,000)	$(1,323,000)	$(1,146,000)
	Medicaid	(245,000)	(1,035,000)	(1,467,000)
Total Net Patient Revenue		**(557,000)**	**(2,358,000)**	**(2,612,000)**
Other Deductions		(242,000)	(926,000)	(1,036,000)
Other Operating Revenue		251,390	1,065,675	1,182,189
Revenue from Operations		**(63,610)**	**(366,325)**	**(393,811)**
Operating Expense (variable)	Salaries	(282,670)	(1,198,125)	(1,329,000)
	Supplies and Drugs	43,240	183,150	203,054
	Other Oper. Expenses	0	0	0
Operating Expense (fixed)	Depreciation	0	0	0
	Interest Expense	0	0	0
	Lease Expense	0	0	0
Total Operating Expense		**(239,430)**	**(1,014,975)**	**(1,125,946)**
Gain from Operations		**$ 233,640**	**$ 937,477**	**$ 732,135**
FTEs		**(4)**	**(16)**	**(16)**
Inpatient Discharges		**(163)**	**(650)**	**(700)**

(March 19, 2008, Late File 3, Exhibit 1)

Table 9c: Projected Incremental Revenues, Expenses, and Gain from Operations for WH

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue*	Non-Government	$(122,535)	$ (505,687)	$ (521,231)
	Medicaid	(210,723)	(869,018)	(922,839)
Total Net Patient Revenue		**(333,258)**	**(1,374,705)**	**(1,444,070)**
Operating Expense (variable)	Salaries	(227,813)	(938,588)	(966,745)
	Professional	(100,000)	(400,000)	(400,000)
	Supplies and Drugs	(25,313)	(104,288)	(107,416)
	Other Oper. Expenses	-	-	-
Operating Expense (fixed)	Depreciation	-	-	-
	Interest	-	-	-
	Lease	-	-	-
Total Operating Expense		**(353,126)**	**(1,442,876)**	**(1,474,161)**
Gain from Operations		**$ 19,867**	**$ 68,170**	**$ 30,091**
FTEs		**(3)**	**(10)**	**(10)**
Inpatient Discharges		**(57)**	**(226)**	**(226)**

* Projections do not include the revenues and expenses for the additional 10 adult medical/surgical beds that will be staffed after the CCMC opens the pediatric inpatient unit at SMH; includes $7,000 for Emergency Department Revenues for each payer group in FY 2008 and $28,000 for each payer group in FY 2009 and 2010.

(March 19, 2008, Late File 3, Exhibit 1)

48. CCMC's projected payer mix for the current year and for the three projected years of the proposal, based on gross patient revenue, are reported in the following table:

Table 10: CCMC's Payer Mix

Payer	Payer Mix			
	FY 2007 Current	FY2008 Projected	FY 2009 Projected	FY 2010 Projected
Medicare	0.2%	0%	0%	0%
Medicaid* (includes other medical assistance and managed care)	41.4%	50%	50%	50%
CHAMPUS and TriCare	1.0%	0%	0%	0%
Commercial Insurers	55.8%	49%	49%	49%
Uninsured	1.6%	1%	1%	1%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity

(December 13, 2007, Initial CON Submission, pages 16 and 21-22)

49. The payer mixes for SMH and WH for the current year and for the total facility for the next three projected years are reported in the following tables:

Table 11a: SMH's Payer Mix

Payer	Payer Mix**			
	FY 2007 Current	**FY2008 Projected**	**FY 2009 Projected**	**FY 2010 Projected**
Medicare*	44.7%	45.0%	45.0%	45.0%
Medicaid* (includes other medical assistance)	14.2%	14.0%	14.0%	14.0%
CHAMPUS and TriCare	0.4%	0.4%	0.4%	0.4%
Commercial Insurers*	37.2%	37.0%	37.0%	37.0%
Uninsured	0.3%	0.3%	0.3%	0.3%
Workers Compensation	3.2%	3.3%	3.3%	3.3%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

(December 13, 2007, Initial CON Submission, page 17)

Table 11b: WH's Payer Mix

Payer	Payer Mix**			
	FY 2007 Current	**FY2008 Projected**	**FY 2009 Projected**	**FY 2010 Projected**
Medicare*	43.0%	43.0%	43.0%	43.0%
Medicaid* (includes other medical assistance)	11.0%	11.0%	11.0%	11.0%
CHAMPUS and TriCare	0.0%	0.0%	0.0%	0.0%
Commercial Insurers*	41.0%	41.0%	41.0%	41.0%
Uninsured	1.0%	1.0%	1.0%	1.0%
Workers Compensation	4.0%	4.0%	4.0%	4.0%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

(December 13, 2007, Initial CON Submission, page 16)

50. The following table reports the payer mix for the pediatric patients discharged from SMH and WH in 2007:

Table 12: Hospital Payer Mix for Pediatric Discharges in 2007

Payer	SMH	WH
Medicare	0%	0%
Medicaid	58.0%	46.5%
CHAMPUS and TriCare	0.3%	0.2%
Commercial Insurers	38.2%	50.0%
Self Pay	1.0%	3.3%
Other	2.5%	0%
Total Pediatric Discharges Payer Mix	**100%**	**100%**

Source: OHCA Hospital Inpatient Discharge Database 2007.

51. The proposal's rate for a semi-private room is $2,600. The average pediatric inpatient per diem reimbursement rates for each hospital are reported in the following table:

Table 13: Average Per Diem Rates for Pediatric Inpatient Services

Hospital	Average Per Diem Rates for Pediatric Inpatient Services	
	Government* ***(Medicare, Medicaid)***	***Non-government*** ***(Commercial, Self-pay, and Others)***
CCMC	$2,137	$2,963
SMH	$850	$1,725
WH	$820	$1,680

(December 13, 2007, Initial CON Submission, page 18 and January 23, 2008, Completeness Response, page 7)

52. There is no State Health Plan in existence at this time. *(December 10, 2007, Initial CON Submission, page 2)*

53. CCMC, SMH, and WH have adduced evidence that the proposal is consistent with their long-range plans. *(December 10, 2007, Initial CON Submission, page 2)*

54. CCMC, SMH, and WH have improved productivity and contained costs through energy conservation, the application of technology, group purchasing, and reengineering. SMH also implemented product standardization and pharmacy standardization, utilization and inventory control. *(December 10, 2007, Initial CON Submission, page 7)*

55. CCMC, SMH, and WH have no teaching or research responsibilities that would change as a result of the proposal. *(December 10, 2007, Initial CON Submission, page 8)*

56. CCMC's unique characteristic of its patient/physician mix is that it is the only freestanding hospital in the state devoted solely to the care of children. It has a full array of pediatric medical and surgical specialists, as well as nursing and ancillary support totally dedicated to the care of children. In addition, it has its own nursing and medical professional and post-graduate education programs that will support the new satellite unit. *(December 10, Initial CON Submission, page 8)*

57. CCMC has sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(December 10, 2007, Initial CON Submission, Attachment 4)*

58. CCMC's rates are sufficient to cover the proposed capital cost and operating costs. *(December 10, 2007, Initial CON Submission, page 13)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. The three hospitals (together, referred to as "Applicants") have presented a plan to collaborate and design a more efficient delivery system for the care of inpatient pediatric patients in the Waterbury area. Although this proposal includes the termination of pediatric inpatient services by WH and SMH, it proposes a 12-bed inpatient pediatric unit that will be located at the SMH facility but owned and operated by CCMC.

The CCMC satellite located at SMH will emulate the look and feel of CCMC's main campus in Hartford. Patients will be admitted to the unit through the emergency departments ("ED") at SMH and WH, or by community physicians from the Waterbury area who elect to have CCMC privileges. A full time medical director and midlevel practitioners will oversee the day-to-day clinical care of patients on with unit, with CCMC physician specialists available for consultation as needed. The attending physician will coordinate follow-up outpatient care for patients discharged from the CCMC inpatient pediatric unit. In the event that a patient requires ongoing specialty care, they will most likely be admitted or transferred to CCMC's main campus in Hartford.

This proposal is the first collaborative venture of this type between CCMC and other providers. The proposal addresses the apparent excess capacity that exists at both SMH and WH while at the same time strengthening the clinical programs and staff competencies through the proposed consolidation of services. SMH currently has 12 pediatric beds, and WH currently has 10 pediatric beds. The pediatric inpatient units at both hospitals have been at approximately 50% capacity during the three most recent fiscal years. The hospitals have a combined average daily census of 6 patients, with a peak of 11 beds and a low of 5 beds. Since it appears that there is excess capacity at both inpatient pediatric units, this proposal's reduction in combined beds from 22 to 12 appears to be reasonable.

OHCA is concerned about access to critical pediatric inpatient services during implementation of the proposal, particularly the transition period between the closing of WH inpatient pediatric unit and the opening of the CCMC inpatient pediatric unit. OHCA is also concerned about the transportation of patients from the WH ED to the CCMC pediatric inpatient unit. Currently WH admits approximately 400 pediatric patients via the ED annually, and it would be this volume of patients that may potentially need

ambulance transport to the CCMC pediatric inpatient unit. OHCA is concerned that additional charges may be incurred by families initially presenting at WH and requiring transfer to CCMC. OHCA questions the impact of these charges and of the ambulance transfer itself on patient satisfaction with the proposed service. Since the unit will be located at SMH, OHCA does not have the same concern with the ED patients at SMH, as they need only be admitted to the CCMC unit on the premises. OHCA is concerned, however, that the proposal may ultimately result in an influx of pediatric volume over time arriving at SMH ED, adding to an already "crowded" ED.

The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. CCMC projects incremental gains from operations with the proposal of $192,894, $742,112, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. SMH projects incremental gains from operations with the proposal of $233,640, $937,477, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. WH projects incremental gains from operations with the proposal of $26,373, $96,654, and $61,034 in fiscal years 2008, 2009, and 2011 respectively. WH's projections do not include any gains/losses from the conversion of 10 pediatric medical/surgical beds to 10 adult medical/surgical beds.

In conclusion, this proposal will improve the quality of and access to specialized pediatric services in the proposed service area through collaboration between hospitals. However OHCA requires that the Applicants address more fully the effects of the proposal and address potential issues related to access, transfer, the admitting process, and other related matters. This approach assures the public of a sound professional facility that will serve the needs of pediatric patients and their families in the greater Waterbury area.

Order

NOW, THEREFORE, the Office of Health Care Access ("OHCA") and Connecticut Children's Medical Center ("CCMC"), Saint Mary's Hospital ("SMH"), and Waterbury Hospital ("WH") (together referred to as "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate pediatric inpatient services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079.

1. The Applicants' request for a Certificate of Need regarding the proposal to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate inpatient pediatric services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079, is hereby approved.

2. CCMC is authorized by OHCA to increase its licensed bed capacity, from 135 licensed beds to 147 licensed beds, an addition of 12 beds. CCMC must also obtain authorization from the State of Connecticut Department of Public Health to increase its licensed bed capacity by 12 beds. These 12 beds can only be staffed and utilized at the new satellite location at SMH and cannot be staffed at any other facility unless CCMC files with OHCA appropriate documentation and receives OHCA approval.

3. SMH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC pediatric inpatient unit is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject SMH to civil penalties pursuant to Section 19a-653, C.G.S.

4. WH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject WH to civil penalties pursuant to Section 19a-653, C.G.S.

5. There is no authorized change in the number of licensed beds at SMH or WH.

6. No less than two weeks prior to start of operations, CCMC shall file with OHCA written notification of the date upon which CCMC will begin operation of the inpatient pediatric unit within SMH. OHCA must receive this notification and acknowledge receipt of such in writing, prior to SMH and WH terminating their inpatient pediatric services. In addition, CCMC is required to file a copy of its license obtained from the State of Connecticut Department of Public Health to operate the satellite inpatient pediatric services unit.

7. The Applicants will create a charitable pool fund to cover any out-of-pocket expenses that the patient's and/or the parent's or legal guardian's health insurer does not cover as related to the transportation from WH ED to the CCMC satellite unit at SMH. It is the Applicants' responsibility to ensure that the patient's parent or legal guardian is aware of this policy. CCMC will administer the charitable pool fund and provide OHCA with the appropriate documentation of its formation. CCMC will report the usage of such funds to OHCA at meetings as stipulated in Condition 15.

8. Patients transported from WH ED to CCMC pediatric inpatient unit shall be directly admitted to the pediatric inpatient unit and shall not be admitted to the SMH Emergency Department ("ED"). In the event this occurs, SMH must cover all expenses related to this second ED visit.

9. SMH and WH will continue to provide outpatient and ED services to children.

10. Should SMH and/or WH propose to recommence pediatric inpatient services, each hospital shall file with OHCA appropriate documentation, including either a Certificate of Need Determination Request or a Certificate of Need Letter of Intent.

11. Should the agreement among the Applicants established by the Memorandum of Understanding be terminated, CCMC must obtain CON authorization from OHCA before termination of its pediatric inpatient unit at SMH.

12. CCMC will work to ensure that all community pediatricians/family practitioners and surgeons who have provided care for children at either or both SMH and WH will elect to have active privileges at CCMC in order to admit patients to the pediatric inpatient unit. CCMC will also reach out to additional practitioners in the Waterbury area in an effort to include all potential pediatric providers.

13. It is the responsibility of CCMC to inform the public of the new pediatric inpatient unit at SMH and that its services will be provided in accordance with the Ethical and Religious Directives for Catholic Health Care Services ("ERD").

14. CCMC shall distribute a Patient Satisfaction Survey to each patient, parent, or legal guardian that has been provided services at the pediatric inpatient unit. The survey shall be able to segment patients originating from WH and SMH EDs and shall have questions that focus on topics that include, but are not limited to:
    - Transfer and transport issues;
    - Prior knowledge of CCMC being the hospital provider;
    - Knowledge of the staff regarding the new satellite unit;
    - Knowledge of the ERD;
    - Overall patient experience, quality; and
    - Any other relevant feedback.

    The results of this survey are most important at the inception of the program and will be required for only the first full twelve months of operations. OHCA requires

that CCMC provide quarterly aggregated results one month after the completion of a calendar quarter.

15. OHCA requires meetings between the Applicants and OHCA concerning the operation of the CCMC pediatric inpatient unit. The first meeting with OHCA shall occur approximately two weeks prior to commencement of the operations of the pediatric inpatient unit. It will be at the discretion of OHCA to determine the frequency and number of future meetings to be held and the information that must be submitted at each meeting. Unless otherwise notified in writing by OHCA the meetings will focus on operational issues or barriers of access to care, including, but not limited to, transfer, admitting process, and ED issues.

16. CCMC must post a toll-free telephone number for patients, parents or legal guardians to call if they have concerns or complaints concerning CCMC pediatric inpatients services at SMH.

17. The Applicants shall provide OHCA with a finalized copy of the Master Service Agreement and each schedule, exhibit, attachment, and addendum to the Agreement within 30 days of execution of the Master Service Agreement.

18. The authorization shall expire on April 30, 2010. Should the termination of existing pediatric inpatient services at SMH and WH and establishment of new satellite pediatric inpatient services with CCMC as the license holder and operator not be completed by that date and available to patients, the Applicants must seek further approval from OHCA to complete the project beyond that date.

19. The Applicants shall not exceed the approved capital expenditure of $600,079. In the event that the Applicants learn of potential cost increases or expect that the final project costs will exceed those approved, the Applicants shall file with OHCA a request for approval of the revised project budget.

20. OHCA and CCMC, SMH, and WH agree that this Agreed Settlement represents a final agreement between OHCA and CCMC, SMH, and WH with respect to this request. The signing of this Agreed Settement resolves all objections, claims and disputes, which may have been raised by the Applicants with regard to Docket Number: 07-31003-CON.

21. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Signed by Martin J. Gavin on April 30, 2008

Date

Duly Authorized Agent for
Connecticut Children's Medical Center

Signed by Michael Novak on April 30, 2008

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by Colleen Scott on May 1, 2008

Date

Duly Authorized Agent for
Waterbury Hospital

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on May 1, 2008.

Signed by Commissioner Vogel on May 1, 2008

_____
Date

_____
Cristine A. Vogel
Commissioner

EXHIBIT 28

Execution Copy

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties.**"

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01.**

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01.**

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06.**

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06.**

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02.**

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"**Certification of AFFAP**" has the meaning set forth in **Section 6.22(c).**

"**Church Plan**" has the meaning set forth in **Section 6.22(e).**

"**Closing**" has the meaning set forth in **Section 5.01.**

"**Closing Date**" has the meaning set forth in **Section 5.01.**

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01.**

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a).**

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04.**

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth in **Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**NE-RHM**" has the meaning set forth in the preamble.

"**NE-RHM Controlled Subsidiary**" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"**NE-RHM Providers**" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"**Trinity Health Controlled Subsidiary**" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"**Withdrawal Liability**" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date.**"

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

cant do: a, b, c, o, q
consent for: d, e h, i, k, m, m, p
notify: f, g, j, l

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c)**, and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15**(a) of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the **"Saint Mary's Insurance Policies"**); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09**(b) of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12.**

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) **"Confidential Information"** means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a **"Disclosing Party"**) or its Representatives to the other Party (a **"Recipient"**) and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term **"Confidential Information"** does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBIT 29

Waterbury Republican
October 27, 2015

Borough 'gateway' unveiled

Developer shares pictures of project plans for Parcel C

BY PAUL SINGLEY
REPUBLICAN-AMERICAN

NAUGATUCK — Borough officials were enthusiastic Monday when developer Rob Oris unveiled pictures of his much anticipated project on Parcel C downtown.

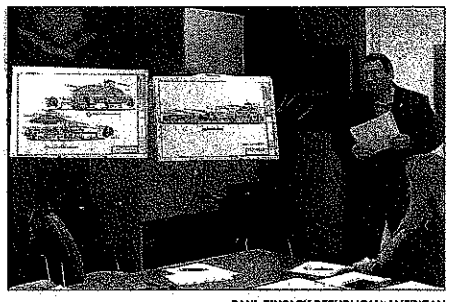
Oris, a veteran developer and Naugatuck native, showed architectural renderings for his proposal, which calls for a three-story, 30,000-square-foot medical office complex and a 5,000-square-foot retail/restaurant facility on the corner of Maple and Water streets.

"Our goal was to create a gateway to Naugatuck that we can all be really proud of," he said. "It's going to kick-start downtown revitalization."

Oris presented to the Naugatuck Economic Development Corp. and the Board of Mayor and Burgesses during separate meetings Monday night. Both boards unanimously approved the project. It will now go through the land use process. If approved, construction would begin in the spring.

The medical complex, which Oris believes will be a draw for people downtown, will be anchored by Saint Mary's Hospital of Waterbury. The first two floors will each be 11,000 square feet, while the third floor will be about 7,500 square feet, Oris said.

See **PARCEL**, *Page* **4B**



PAUL SINGLEY REPUBLICAN-AMERICAN

Developer Rob Oris shows renderings of his proposal for Parcel C in Naugatuck to borough officials Monday night.

PARCEL: Partners seek 'higher end' tenants

The buildings will face Maple Street and parking will be in the back. The renderings show a stucco material for the siding that is a mix of maroon and beige colors on the facade, a physical therapy fitness facility on the top floor and an outdoor seating area on the top floor.

There will be a courtyard in the front of the development with flower beds and a large flagpole. People will primarily enter the building from the back, where the parking lot is located.

Oris said the goal was to make the buildings look similar to the more appealing buildings in Naugatuck's downtown.

He said he is speaking with "an upscale coffee shop" to be a tenant in the smaller building, but stopped short of saying it is Starbucks.

The other tenant in the smaller building will be a bank. Both will have drive-thru windows.

Oris' partner, veteran developer John Lombard, said he thinks the traditional phrase of "if you build it, they will come" is not exactly what the developers were going for with this project.

"What's more important is who will come," Lombard said. "We're not out to attract a low-end tenant. We're trying to attract higher-end tenants.

"If we have that draw, what happens across the street (with future developments) is also going to feed off this," he said. "We're looking to bring in the best tenants, who are paying the most money and are successful over the long term."

Contact Paul Singley at psingley@rep-am.com, on Facebook at RA Naugatuck or on Twitter @RANaugatuck.

PAUL SINGLEY REPUBLICAN-AMERICAN

These are renderings of a developer's plans for Parcel C in downtown Naugatuck. The plans call for a medical office complex and a second building that will have both an 'upscale coffee maker' and a bank, both with drive-thru windows. Naugatuck officials approved the plans Monday night.

EXHIBIT 30

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$746,752	$786,099		$786,099	$825,404		$825,404	$866,674		$866,674	$910,008		$910,008
2	Less: Allowances	$484,798	$513,815		$513,815	$545,158		$545,158	$578,412		$578,412	$613,695		$613,695
3	Less: Charity Care	$1,854	$1,947		$1,947	$2,044		$2,044	$2,146		$2,146	$2,254		$2,254
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	$255,868	$260,591	$0	$260,591	$268,456	$0	$268,456	$276,370	$0	$276,370	$284,313	$0	$284,313
5	Medicare	$98,309	$100,067		$100,067	$103,087		$103,087	$106,126		$106,126	$109,176		$109,176
6	Medicaid	$47,555	$45,864		$45,864	$47,248		$47,248	$48,641		$48,641	$50,039		$50,039
7	CHAMPUS & TriCare	$199	$1,824		$1,824	$1,879		$1,879	$221		$221	$227		$227
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	$146,062	$147,755	$0	$147,755	$152,215	$0	$152,215	$154,988	$0	$154,988	$159,443	$0	$159,443
9	Commercial Insurers	$92,482	$95,376		$95,376	$98,255		$98,255	$101,151		$101,151	$104,058		$104,058
10	Uninsured	$8,522	$8,600		$8,600	$8,859		$8,859	$9,120		$9,120	$9,382		$9,382
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$7,785	$7,818		$7,818	$8,054		$8,054	$8,291		$8,291	$8,529		$8,529
13	Other	$1,017	$1,042		$1,042	$1,074		$1,074	$1,105		$1,105	$1,137		$1,137
	Total Non-Government	$109,806	$112,836	$0	$112,836	$116,242	$0	$116,242	$119,668	$0	$119,668	$123,107	$0	$123,107
	Net Patient Service Revenue (Government+Non-Government)	$255,868	$260,591	$0	$260,591	$268,456	$0	$268,456	$274,656	$0	$274,656	$282,550	$0	$282,550
14	Less: Provision for Bad Debts	$8,180	$8,512		$8,512	$8,938		$8,938	$9,384		$9,384	$9,854		$9,854
	Net Patient Service Revenue less provision for bad debts	$247,688	$252,079	$0	$252,079	$259,519	$0	$259,519	$266,985	$0	$266,985	$274,459	$0	$274,459
15	Other Operating Revenue	$7,473	$6,267		$6,267	$6,267		$6,267	$6,267		$6,267	$6,267		$6,267
17	Net Assets Released from Restrictions	$733	$700		$700	$700		$700	$700		$700	$700		$700
	TOTAL OPERATING REVENUE	$255,894	$259,046	$0	$259,046	$266,486	$0	$266,486	$273,952	$0	$273,952	$281,426	$0	$281,426
B.	OPERATING EXPENSES													
1	Salaries and Wages	$88,793	$93,086		$93,086	$95,413		$95,413	$97,798		$97,798	$100,243		$100,243
2	Fringe Benefits	$27,562	$25,721		$25,721	$26,364		$26,364	$27,023		$27,023	$27,699		$27,699
3	Physicians Fees	$10,621	$11,268		$11,268	$11,606		$11,606	$11,954		$11,954	$12,313		$12,313
4	Supplies and Drugs	$45,059	$44,320		$44,320	$46,536	($652)	$45,884	$48,863	($1,368)	$47,495	$51,306	($1,437)	$49,869
5	Depreciation and Amortization	$10,805	$11,116		$11,116	$11,449		$11,449	$11,793		$11,793	$12,147		$12,147
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$963	$216		$216	$205		$205	$195		$195	$185		$185
8	Malpractice Insurance Cost	$5,350	$5,094		$5,094	$5,196		$5,196	$5,300		$5,300	$5,406		$5,406
9	Lease Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$48,175		$48,175	$49,139	($708)	$48,431	$50,121	($1,403)	$48,718	$51,124	($1,431)	$49,692
	TOTAL OPERATING EXPENSES	$238,198	$238,996	$0	$238,996	$245,908	($1,359)	$244,549	$253,048	($2,772)	$250,276	$260,422	($2,868)	$257,554
	INCOME/(LOSS) FROM OPERATIONS	$17,696	$20,050	$0	$20,050	$20,577	$1,359	$21,936	$20,904	$2,772	$23,676	$21,004	$2,868	$23,872
	NON-OPERATING REVENUE	$3,158	$3,716		$3,716	$3,827		$3,827	$3,942		$3,942	$4,061		$4,061

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$20,854	$23,766	$0	$23,766	$24,405	$1,359	$25,764	$24,847	$2,772	$27,618	$25,041	$2,868	$27,932
	Principal Payments	$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000
7C	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	6.8%	7.6%	0.0%	7.6%	7.5%	0.0%	8.1%	7.5%	0.0%	8.5%	7.4%	0.0%	8.4%
2	Hospital Non Operating Margin	1.2%	1.2%	0.0%	1.2%	1.1%	0.0%	1.1%	1.1%	0.0%	1.1%	1.1%	0.0%	1.1%
3	Hospital Total Margin	8.1%	9.0%	0.0%	9.0%	9.0%	0.0%	9.5%	8.9%	0.0%	9.9%	8.8%	0.0%	9.8%
D.	FTEs	1,384	1,415		1,415	1,415		1,415	1,415		1,415	1,415		1,415
E.	VOLUME STATISTICS													
1	Inpatient Discharges	11,847	11,875		11,875	11,816		11,816	11,757		11,757	11,698		11,698
2	Outpatient Visits	238,522	246,611		246,611	251,543		251,543	256,574		256,574	261,706		261,706
	TOTAL VOLUME	250,369	258,486	0	258,486	263,359	0	263,359	268,331	0	268,331	273,404	0	273,404

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EBIDA	$29,464	$31,382	$31,382	$32,232	$33,591	$32,892	$35,664	$33,336	$36,204
	11.5%	12.1%	12.1%	12.1%	12.6%	12.0%	13.0%	11.8%	12.9%

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:		(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected
	Description		Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON
	Assumptions												
	Total Gross Patient Revenue	5.0%											
	Less: Allowances	6.1%											
	Less: Charity Care	5.0%											
	Less: Other Deductions	5.0%											
	Less: Provision for Bad Debts												
14	Less: Provision for Bad Debts	5.0%											
5	Net Patient Service Revenue less provision for bad debts												
15	Other Operating Revenue												
17	Net Assets Released from Restrictions												
	Salaries and Wages	2.5%											
	Fringe Benefits	2.5%											
	Physicians Fees	3.0%											
	Supplies and Drugs	5.0%											
	Depreciation and Amortization	3.0%											
	Provision for Bad Debts-Other[b]	2.0%											
	Interest Expense	-5.0%											
	Malpractice Insurance Cost	2.0%											
	Lease Expense	2.0%											
	Other Operating Expenses	2.0%											
	NON-OPERATING REVENUE	3%											
	Medicare		38.42%	38.4%			38.4%			38.4%			38.4%
	Medicaid		18.59%	17.6%			17.6%			17.6%			17.6%

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NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON
	Description											
	CHAMPUS & TriCare	0.08%	0.7%			0.7%			0.1%			0.1%
	Other	0.00%	0.0%									
	Total Government	0.00%	56.7%			56.7%			56.1%			56.1%
	Commercial Insurers	36.14%	36.6%			36.6%			36.6%			36.6%
	Uninsured	3.33%	3.3%			3.3%			3.3%			3.3%
	Self Pay	0.00%	0.0%			0.0%			0.0%			0.0%
	Workers Compensation	3.04%	3.0%			3.0%			3.0%			3.0%
	Other	0.40%	0.4%			0.4%			0.4%			0.4%
	Total Non-Government	0.00%	43.3%			43.3%			43.3%			43.3%
		0.00%	100.0%			100.0%			99.4%			99.4%

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$832,217	$873,828		$873,828	$917,519		$917,519	$963,395		$963,395	$1,011,565		$1,011,565
2	Less: Allowances	$535,300	$558,162		$558,162	$592,210		$592,210	$628,335		$628,335	$666,663		$666,663
3	Less: Charity Care	$1,854	$2,500		$2,500	$2,625		$2,625	$2,756		$2,756	$2,894		$2,894
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	$290,831	$303,420	$0	$303,420	$312,938	$0	$312,938	$322,558	$0	$322,558	$332,262	$0	$332,262
5	Medicare	$111,743	$116,513		$116,513	$120,168		$120,168	$123,862		$123,862	$127,589		$127,589
6	Medicaid	$54,053	$53,402		$53,402	$55,077		$55,077	$56,770		$56,770	$58,478		$58,478
7	CHAMPUS & TriCare	$226	$2,124		$2,124	$2,191		$2,191	$2,258		$2,258	$2,326		$2,326
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	$166,021	$172,039	$0	$172,039	$177,436	$0	$177,436	$182,891	$0	$182,891	$188,392	$0	$188,392
9	Commercial Insurers	$105,120	$111,052		$111,052	$114,535		$114,535	$118,056		$118,056	$121,608		$121,608
10	Uninsured	$9,686	$10,013		$10,013	$10,327		$10,327	$10,644		$10,644	$10,965		$10,965
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,849	$9,103		$9,103	$9,388		$9,388	$9,677		$9,677	$9,968		$9,968
13	Other	$1,155	$1,214		$1,214	$1,252		$1,252	$1,290		$1,290	$1,329		$1,329
	Total Non-Government	$124,810	$131,381	$0	$131,381	$135,502	$0	$135,502	$139,668	$0	$139,668	$143,869	$0	$143,869
	Net Patient Service Revenue (Government+Non-Government)	$290,831	$303,420	$0	$303,420	$312,938	$0	$312,938	$322,558	$0	$322,558	$332,262	$0	$332,262
14	Less: Provision for Bad Debts	$9,675	$9,990		$9,990	$10,490		$10,490	$11,014		$11,014	$11,565		$11,565
	Net Patient Service Revenue less provision for bad debts	$281,156	$293,430	$0	$293,430	$302,449	$0	$302,449	$311,544	$0	$311,544	$320,697	$0	$320,697
15	Other Operating Revenue	$6,248	$7,253		$7,253	$7,253		$7,253	$7,253		$7,253	$7,253		$7,253
17	Net Assets Released from Restrictions	$733	$733		$733	$733		$733	$733		$733	$733		$733
	TOTAL OPERATING REVENUE	$290,137	$301,416	$0	$301,416	$310,435	$0	$310,435	$319,530	$0	$319,530	$328,683	$0	$328,683
B.	OPERATING EXPENSES													
1	Salaries and Wages	$123,041	$132,928		$132,928	$136,251		$136,251	$139,657		$139,657	$143,149		$143,149
2	Fringe Benefits	$32,244	$30,602		$30,602	$31,367		$31,367	$32,151		$32,151	$32,955		$32,955
3	Physicians Fees	$9,915	$11,031		$11,031	$11,362		$11,362	$11,703		$11,703	$12,054		$12,054
4	Supplies and Drugs	$47,026	$48,991		$48,991	$51,441	($720)	$50,720	$54,013	($1,512)	$52,500	$56,713	($1,588)	$55,125
5	Depreciation and Amortization	$11,502	$11,713		$11,713	$12,064		$12,064	$12,426		$12,426	$12,799		$12,799
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$979	$231		$231	$219		$219	$208		$208	$198		$198
8	Malpractice Insurance Cost	$5,572	$5,917		$5,917	$6,035		$6,035	$6,156		$6,156	$6,279		$6,279
9	Lease Expense				$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,631	$55,648		$55,648	$56,761	($817)	$55,944	$57,896	($1,621)	$56,275	$59,054	($1,654)	$57,401
	TOTAL OPERATING EXPENSES	$287,910	$297,061	$0	$297,061	$305,501	($1,538)	$303,963	$314,211	($3,133)	$311,078	$323,204	($3,241)	$319,960
	INCOME/(LOSS) FROM OPERATIONS	$2,227	$4,355	$0	$4,355	$4,934	$1,538	$6,472	$5,319	$3,133	$8,453	$5,482	$3,241	$8,723
	NON-OPERATING REVENUE	$2,190	$2,877		$2,877	$2,963		$2,963	$3,052		$3,052	$3,144		$3,144
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$4,417	$7,232	$0	$7,232	$7,897	$1,538	$9,435	$8,371	$3,133	$11,505	$8,625	$3,241	$11,867

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NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Principal Payments	$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	0.8%	1.4%	0.0%	1.4%	1.8%	0.0%	1.8%	1.6%	0.0%	1.6%	1.7%	0.0%	1.7%
2	Hospital Non Operating Margin	0.7%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%
3	Hospital Total Margin	1.5%	2.4%	0.0%	2.4%	2.8%	0.0%	2.8%	2.6%	0.0%	2.6%	2.6%	0.0%	2.6%
D.	FTEs	1,680	1,754		1,754	1,754		1,754	1,754		1,754	1,754		1,754
E.	VOLUME STATISTICS													
1	Inpatient Discharges	11,647	11,875		11,875	11,816		11,816	11,757		11,757	11,698		11,698
2	Outpatient Visits	238,522	246,611		246,611	251,543		251,543	256,574		256,574	261,706		261,706
	TOTAL VOLUME	250,169	258,486	0	258,486	263,359	0	263,359	268,331	0	268,331	273,404	0	273,404

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EBIDA	$14,708	$16,299	$16,299	$17,218	$18,755	$17,954	$21,087	$18,479	$21,720
	5.1%	5.4%	5.4%	5.5%	6.0%	5.6%	6.6%	5.6%	6.6%

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Assumptions													
	Total Gross Patient Revenue	5.0%												
	Less: Allowances	6.1%												
	Less: Charity Care	5.0%												
	Less: Other Deductions	5.0%												
	Less: Provision for Bad Debts													
14	Less: Provision for Bad Debts	5.0%												
	Net Patient Service Revenue less provision for bad debts													
15	Other Operating Revenue													
17	Net Assets Released from Restrictions													
	Salaries and Wages	2.5%												
	Fringe Benefits	2.5%												
	Physicians Fees	3.0%												
	Supplies and Drugs	5.0%												
	Depreciation and Amortization	3.0%												
	Provision for Bad Debts-Other[b]	2.0%												
	Interest Expense	-5.0%												
	Malpractice Insurance Cost	2.0%												
	Lease Expense	2.0%												
	Other Operating Expenses	2.0%												
	NON-OPERATING REVENUE	3%												
	Medicare	38%	38.4%			38%			38%			38%		
	Medicaid	19%	17.6%			18%			18%			18%		
	CHAMPUS & TriCare	0%	0.7%			1%			1%			1%		
	Other	0%	0.0%			0%			0%			0%		
	Total Government	0.0%	56.7%			57%			57%			57%		
	Commercial Insurers	36%	36.6%			37%			37%			37%		
	Uninsured	3%	3.3%			3%			3%			3%		
	Self Pay	0%	0.0%			0%			0%			0%		
	Workers Compensation	3%	3.0%			3%			3%			3%		
	Other	0.4%	0.4%			0%			0%			0%		
	Total Non-Government	0.0%	43.3%			43%			43%			43%		

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
		0.0%	100.0%			100%			100%			100%		

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, February 26, 2016 3:01 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: Completeness Letter 2: 15-32045-CON
Attachments: 15-32045 Completeness Letter Two 2.26.16 FINAL.docx

Dear Mr. Hartley and Mr. Anthony:

Attached please find a second completeness letter for Trinity and Saint Mary's CON application (docket number 15-32045). Instructions for responding are included in the body of the attached letter. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact us. Have a good weekend.

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

February 26, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: **Completeness Questions, Docket Number: 15-32045-CON**
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

On January 29, 2016, OHCA received responses from the Applicant to OHCA's completeness questions. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a- 639a(c) and requests additional information.

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than **April 26, 2016**, otherwise your application will be automatically considered withdrawn.

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

1. With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?

2. Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?

3. Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:

    a) Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?

    b) If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?

    c) Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?

    d) Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?

4. For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:

    a) Chelsea Community Hospital
    b) Mercy Health Systems
    c) St. Alphonsus Regional Medical Center
    d) Loyola University Health System
    e) Catholic Health East

f) St. Joseph Health, Inc.

5. Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:

   a) St. Alphonsus Regional Medical Center
   b) St. Francis Hospital and Medical Center
   c) Johnson Memorial Hospital
   d) St. Joseph Health, Inc.
   e) Loyola University Health Systems
   f) Mercy Health Systems

Please email your responses to all of the following email addresses: OHCA@ct.gov, OHCA@ct.gov, jessica.schaeffer-helmecki@ct.gov, kaila.riggott@ct.gov; david.fernandes@ct.gov; ron.ciesones@ct.gov.

If you have any questions concerning this letter, please feel free to contact us.

Sincerely,

Ron Ciesones
Health Care Analyst
Ron.Ciesones@ct.gov
(860) 418-7030

Jessica Schaeffer-Helmecki
Planning Analyst
Jessica.Schaeffer-Helmecki@ct.gov
(860) 509-8075

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, February 26, 2016 3:41 PM
To: Greer, Leslie
Subject: FW: Completeness Letter 2: 15-32045-CON
Attachments: Read: Completeness Letter 2: 15-32045-CON

Read Receipt

-----Original Message-----
From: Hartley, Christopher [mailto:CHartley@stfranciscare.org]
Sent: Friday, February 26, 2016 3:04 PM
To: Schaeffer-Helmecki, Jessica
Subject: Read: Completeness Letter 2: 15-32045-CON

NOTICE: This email and/or attachments may contain confidential or proprietary information which may be legally privileged. It is intended only for the named recipient(s). If an addressing or transmission error has misdirected this email, please notify the author by replying to this message. If you are not the named recipient, you are not authorized to use, disclose, distribute, make copies or print this email, and should immediately delete it from your computer system. Saint Francis Care has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Care accepts no liability for any damage caused by any virus transmitted by this email.

Saint Mary's HOSPITAL

March 11, 2016

Via Email

Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find our responses to OHCA's February 26, 2016 letter regarding the above referenced Certificate of Need application. We are hopeful that these answers will allow us to move forward with Saint Mary's Hospital Inc.'s joining Trinity Health – New England, Inc. fka Saint Francis *Care* Inc.

As always should you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: Robert Anthony /af
Robert Anthony
General Counsel
Saint Mary's Health System

By: Chris Hartley
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.

Enclosures

1. **With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?**

   The amount Trinity Health currently charges to Regional Heath Ministries (RHMs) is 0.8% of operating expenses which was reduced over the last few years from 1% of operating expenses. Typically, organizations are not subject to this charge until one year after the transaction has occurred; however, the services are available immediately. This is the case for Saint Francis, Johnson Memorial Medical Center, and Saint Mary's. The allocation methodology is consistent for all similarly-situated RHMs. For example, the NE-RHM will be charged $8.9 million annually beginning 10/1/2016 for Saint Francis and its subsidiaries. As the NE-RHM continues to grow, the charge will increase based upon the incremental operating expenses of new organizations (e.g., Saint Mary's) within the NE-RHM. The NE-RHM would then be responsible for allocating the charge to its local hospitals and other subsidiaries. This charge is calculated annually and we would anticipate the allocation would decrease as we become more efficient through integration with the NE-RHM. This overhead allocation is to cover the costs associated with corporate functions that both strategically and operationally benefit all hospitals and RHMs and include but are not limited to the following:

   - Clinically Integrated Networks (CIN) group helps to position the organization to develop and support CINs in every market and to establish market position for the future delivery model under accountable care.

   - Provider Network Operations provides executive leadership to support the employed physician practices and drive consistent practices in operating models. There are over 3,900 employed physicians and this team works on strategic direction, synergies in the practices, productivity, and provides a standard for creating efficiencies and compensation and practice productivity models.

   - Clinical Resources group provides support and coordination of standard clinical practices and protocols, clinical analytics to evaluate and improve clinical scorecard indicators, Tiger teams to develop improvements, and clinical collaboratives for areas such as sepsis, falls, pressure ulcers, congestive heart failure, labor and delivery, etc.

   - Tax department is responsible for preparation and consulting for all federal, state and local tax compliance and is responsible for all in-house consulting and 990 and 1120 tax return preparation. The tax department is staffed by CPAs with extensive healthcare experience and provides support and coordination for any RHM under IRS or local tax audit.

   - External audit fees are included in the system allocation as the audit is performed on a

system-wide basis.

- The Organizational Integrity, Audit and Compliance department provides insourced services with strong compliance department talent, consistent compliance polices and education designed to support an effective compliance program. Organizational Integrity, Audit and Compliance strongly support RHMs on billing and coding. The internal audit department of CPAs supports local RHM management and governance to provide risk based internal audit assurance and also includes specialists in information technology internal audit.

- Legal Services provides insourced legal support for all corporate legal services including merger and acquisitions, joint ventures, physician contracts, contracting with vendors for non-labor and employee labor relations.

These system departments will reduce the amount of direct expenses Saint Mary's, Saint Francis, and Johnson Memorial Medical Center have incurred historically as many of these resources were outsourced to accounting, legal, and consulting firms.

2. **Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?**

   No, future acquisitions will not erode the capital available to Saint Mary's.

3. **Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:**

   a) **Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?**

      As noted on page 635 of the Saint Francis CON, "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development." The NE-RHM determined that Saint Mary's is an important element for its strategic growth and, as such, has determined a portion of the $275 million capital commitment to SFC will be allocated to Saint Mary's. SFC is in full support of this strategic investment.

b) **If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?**

If the 8% cash flow margin is achieved and Saint Mary's receives an additional $20 million of capital commitment, then it would be considered part of the $275 million of capital commitments made to SFC. Again, SFC believes Saint Mary's is an important strategic investment and has chosen to invest a portion of its capital in Saint Mary's.

c) **Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015 that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?**

Yes, as noted in 3 a) above, Trinity Health/NE-RHM had planned for capital expenditures committed for Saint Francis *Care* to be available for "strategic growth including potential mergers, acquisitions, joint ventures and physician network development." Of key importance to Saint Francis *Care* was joining Trinity Health to allow access to capital to support its goal of strategic growth and expansion within Connecticut and the region. Saint Mary's and Johnson Memorial represent such investments.

Please note, however, although Trinity Health/NE-RHM hoped both organizations referenced above would join its health system, there were both federal and state regulatory and legal approvals as well as independent Board approvals that had to occur before either organization could join NE-RHM.

d) **Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?**

No additional capital commitments have been made.

4. **For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:**

a) Chelsea Community Hospital
b) Mercy Health Systems

c) St. Alphonsus Regional Medical Center
d) Loyola University Health System
e) Catholic Health East
f) St. Joseph Health, Inc.

Overall, performance of these hospitals has benefitted from their affiliation with Trinity Health. Examples of specific savings that have been realized in these transactions are as follows:

- Chelsea Community Hospital, Chelsea, Michigan – Tangible benefits included:
    - Revenue growth of 40% between FY 2011 and FY 2016 driven by improved mix associated with surgery volume growth, practice acquisitions and outpatient growth.
    - Best practice outcomes in patient satisfaction, employee engagement and physician satisfaction.
    - Significant site capital investments based on its Master Facility Plan (e.g. new tower including conversion to private acute beds, expanding surgery and increasing ancillary and support space to backfill areas) have occurred totaling approximately $67M to improve environment of care and competitiveness.
    - Operating margin improved from 0.6% pre-merger to 4.4% currently
- Mercy Health, Hackley Campus – (Formerly Hackley Health System), Muskegon, Michigan - annual aggregate savings of $1 million, including from enhanced revenue management and reduced supply and vendor costs. Recently, Healthgrades announced hospitals that received Healthgrades 2016 America's Best Hospitals Award; Mercy Health – Hackley Campus received this award. Mercy Health – Hackley Campus reported an operating margin of -1.0% for the year ended June 2009, the first full year after they joined Trinity Health. Operating margin has improved substantially since then and for the year ended June 2015, Mercy Health – Hackley Campus reported operating margin of 10%.
- Three hospitals owned by Catholic Health Initiatives (Mercy Medical Center, in Nampa, ID; Holy Rosary Medical Center, in Ontario, OR; and St. Elizabeth Health Services, in Baker City, OR) were combined with Trinity Health's

Regional Medical Center in Boise, Idaho to create a new Regional Health Ministry, St. Alphonsus, which resulted in:

- Stabilizing financial performance across the region and specifically at Nampa campus with Operating Cash Flow Margin currently at 16.3%, up from 6.4% in FY 11. Operating margin is also strong and is currently at 9.8%.

- Successfully implemented Cerner EMR system at all three campuses in FY 13.

- Over $225M in investments are planned for relocation of the Nampa campus, which was in need of significant improvements, to a new location that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction.

- Loyola University Health System, Maywood, Illinois - In the first year of joining Trinity Health, Loyola improved its operational performance by $44.5 million across support functions including insurance/risk management, organizational integrity, supply chain, treasury, information services and revenue cycle. Additionally, operating margin and operating cash flow margins have improved substantially over time from -1.4% and 4.0%, respectively, at the time of the transaction, to 1.2% and 6.5% in fiscal 2015.

Also, as noted on page 872 of Docket No: 15-32045-CON cost savings have been realized as a result of the system-level merger with Catholic Health East as well as the recent acquisition of St. Joseph Health located in Syracuse, New York.

Timing of realization of savings is different in all cases; however, Trinity Health focuses on planning for and realizing savings as soon as possible after acquisition. Once savings are realized in a given year, those savings typically continue into the future. Trinity Health and its Regional Health Ministry's continuously look for opportunities for improvement in performance, whether related to Trinity Health system initiatives or strategic initiatives in the local markets. The recent acquisitions and other Trinity Health hospitals continue to benefit from Trinity Health's strong financial position which is supported by Trinity Health's ability to maintain strong ratings for several years. Most recent ratings are:

Moody's – Aa3, stable outlook, 12/21/15, S&P – AA-, stable outlook, 12/23/15, Fitch – AA, negative outlook, 12/30/15.

Although significant positive operational and financial results are realized, these hospitals as well as local hospitals in Connecticut are continuously challenged with decreasing reimbursement from both government and commercial payors and declining volumes. These external factors make it even more critical for local hospitals to leverage some of the resources of a larger health system.

5. **Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:**

    a) St. Alphonsus Regional Medical Center
    b) St. Francis Hospital and Medical Center
    c) Johnson Memorial Hospital
    d) St. Joseph Health, Inc.
    e) Loyola University Health Systems
    f) Mercy Health Systems

Pricing changes are operational in nature and are made as part of ongoing business decisions and are not made as a result of Trinity Health acquisitions. None of these acquisitions were made in order to increase or decrease the price structure of the entity. For Saint Francis Hospital and Medical Center, Johnson Memorial Hospital, St. Joseph Health, Inc., Loyola University Health System and Mercy Health Muskegon - Hackley campus, which is part of Mercy Health, there were no changes in price structure resulting from the acquisition. St. Alphonsus Medical Center – Nampa (Nampa, ID), part of the St. Alphonsus Regional Health Ministry did increase prices by approximately 12% following its acquisition as prior to the acquisition Nampa prices had not been increased for four years.

Greer, Leslie

From: Fernandes, David
Sent: Wednesday, April 06, 2016 11:10 AM
To: chartley@stfrancis.org; banthony@stmh.org
Cc: Schaeffer-Helmecki, Jessica; Riggott, Kaila; Greer, Leslie; Ciesones, Ron
Subject: CON-32045 Deemed Complete
Attachments: 15-32045-CON Notification of Application Deemed Complete.docx

Dear Mr. Hartley and Mr. Anthony:

Please see the attached letter deeming complete the above reference application. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

Thanks,

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 6, 2016

Via Email Only

chartley@stfrancis.org
Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

banthony@stmh.org
Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of April 5, 2016.

If you have any questions concerning this letter, please feel free to contact either me at (860) 418-7032, Jessica Schaeffer-Helmecki at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

David Fernandes

David Fernandes
Planning Analyst (CCT)

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Greer, Leslie
Sent: Monday, April 18, 2016 4:19 PM
To: 'chartley@stfranciscare.org'; 'BAnthony@Stmh.org'
Cc: Fernandes, David; Schaeffer-Helmecki, Jessica; Ciesones, Ron
Subject: Saint Mary's Health System, Inc. and Trinity Health, Inc. Hearing Notice
Attachments: 32045_201604181610.pdf

Mr. Hartley & Mr. Anthony,
Attached is the hearing notice for the Saint Mary's Health System, Inc. and Trinity Health, Inc. scheduled on May 9, 2016.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 18, 2016

Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

RE: Certificate of Need Application, Docket Number 15-32045-CON
Saint Mary's Health System, Inc., and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Dear Mr. Hartley,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Saint Mary's Health System Inc. and Trinity Health, Inc. ("Applicants") on April 5, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s): Saint Mary's Health System, Inc.
Trinity Health, Inc.

Docket Number: 15-32045-CON

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: May 9, 2016

Time: 3:00 p.m.

Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Republican American* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:DF:JSH:RC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 18, 2016 P.O. #54772

Republican American
389 Meadow Street
P.O. Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, April 20, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association
KRM:DF:JSH:RC;lmg

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Republican American
Notice of Public Hearing, Docket Number 15-32045-CON

April 18, 2016

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Saint Mary's Health System Inc. Trinity Health Inc.
Town:	Waterbury
Docket Number:	15-32045-CON
Proposal:	Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.
Date:	May 9, 2016
Time:	3:00 p.m.
Place:	Courtyard by Marriott Waterbury 63 Grand Street Waterbury, CT 06702

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Monday, April 18, 2016 4:24 PM
To: Greer, Leslie
Subject: Re: DN: 15-32045-CON Hearing Notice

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 4:09 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Tuesday, April 19, 2016 4:57 PM
To: Greer, Leslie
Subject: FW: DN: 15-32045-CON Hearing Notice
Attachments: 15-32045 Republican American.docx

Good afternoon,

This notice is set to publish tomorrow.
$190.83

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Tue, 19 Apr 2016 09:27:42 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN: 15-32045-CON Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 5:24 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: RE: DN: 15-32045-CON Hearing Notice

Attached is the word version.

From: ADS [mailto:ADS@graystoneadv.com]
Sent: Monday, April 18, 2016 4:30 PM
To: Greer, Leslie
Subject: Re: DN: 15-32045-CON Hearing Notice

Good day,

Thank you for your ad request.

We can not pull the text off of the attachment, please re-send asap.

Thank you
Graystone Group Advertising

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 4:09 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Real Estate For Rent

Apartments
Condos
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Suburban
Vacation
Wanted to rent

Apartments for rent

APTS FOR RENT-WATERBURY
SECTION 8 WELCOME
2-3 BR, BEACON ST
3 BR, 19 TAYLOR ST
3 BR, 131 OAK ST
Se habla espanol
JOEL ROSARIO, Owner/Broker
Call Today 203-217-2593
A Home Connection R.E

NAUGATUCK 1 bedroom $725; Prospect Manor, lndry, storage, prkg, nice sec/ref. 203-753-3239

NAUGATUCK 3 BR, 6rms 1st floor 11 Maple Terrace, No pets. 1st, last, security. Call 203-725-5823

NAUGATUCK duplex 3 BR appl, W/D hkup, 2 baths, gar, no pets / smk $1200+sec 203-758-4327

OAKVILLE 1br 2nd flr, no smoke/no pets, H/HW elec., stove/fridge incl., close to Rte 8. $850+1 mo sec. **860-274-5841**

WATERBURY 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

WATERBURY 1, 2, 3, 4 BR Apts & Houses available **NEWLY RENOVATED** Agent 203-565-9639

WATERBURY 1, 2 & 3 rm apts clean, appl, util secure bldg lndry $465/up. Sect 8 OK. 203-753-3239

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY $1200 4 BR, brand new - just rebuilt. 1½ baths, convenient to I-84. **Velezis Realty, 203-574-7777.**

WATERBURY 174 Willow St. **studios, 1br** start @ $450 H/HW incl Sect 8 ok. 203-510-6177

WATERBURY **1BR, 2BR, 3BR** available starting @ $550. Section 8 accepted. 203-510-6177

WATERBURY 1BR & 2BR, No pets, on-site laundry. Starting at $650. Call 860-810-2941

WATERBURY 1BR *Must see, new!* Cabinets, appl, Priv, off st pk, no smk/pets $750 neg. 203 756 1140

WATERBURY 3 & 4 BR Chestnut Av WD hkups, remod, clean, no pets. Sec 8 $875 & up. 203-558-5142

WATERBURY 3 BR 199 Chestnut Ave., 3rd flr., large rooms, quiet, no pets, $750/mo. 203-722-7171

WATERBURY 3 BR, nice, HW floors, heat, parking & laundry included $800 (203) 206-4051

WATERBURY
5 RM/2 BR Town Plot - very spacious, hardwood floors. 1st floor **$850**, 2nd floor **$825**.
5RM/2 BR Town Plot - 1st flr, **$800**
4 RM/2 BR 1st and 2nd floor, 4-plex Town Plot, **$800**
OAKVILLE
6 RM/3 BR Raised Ranch - finished basement, 1 car garage. Sm. dog considered. **$1,500**
Farmingbury Real Estate
203-879-6491

WATERBURY 98 Rose St. **3**BR hardwood floors, gar., yard, $850+sec. Call 203-756-6339.

Apartments for rent

WATERBURY DOWNTOWN
Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $610; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

WATERBURY
EAST END APTS. some newly renovated, on busline, convenient to shopping, laundry on premises. $650-$675. Credit check. 203-725-6121

WATERBURY Giles St. 2BR, 1 bath, LR, DR, sunroom, gar. incl. gas heat, $890 No utils. 203-769-0898

WATERBURY Must see 1st flr. 2BR apt quiet dead end, W/D incl, Lg. inside porch, $750. 860 997 5468

WATERBURY spacious studio & 1BR & 2BR. $625, $750 & $850. Call for details 203-906-0817

WATERBURY STUDIO & 1 BR
41 Prospect St. Subsidized unit
Call Cristina 203-509-2025
Call Rose 203-560-9702

WATERBURY Town Plot 1st flr 2BR, appls incl, No pets. $875+2mos sec. 203-232-4693

WATERBURY **Town Plot** 2br $850. & **Hopeville** 2br $795. Call 203-729-2269, 203-805-1680

WATERBURY Town Plot 2BR, appl WD hkup, w/w, busline, no pets $850 cr ck sec 860-274-9554

WATERBURY Town Plot, 5RM 2nd floor, fresh paint, hdwd flrs. 649 Wilson St. No pets. 860-378-5877

WATERBURY Town Plot huge modern 8 rms, quiet nghbrhd, no pets, good ref. & cr. check $1100/mo. **914-906-5489**

Waterbury/Wolcott Line
Mod. elev. bldgs convenient well maintained **HILLTOP MANOR** Studios $570; 1 BR from $670; **LIBERTY COURT** heat, HW, elect. incl.; studios $650+; 1 BR $790+; Both incl. prkg., carpet/HW flrs, sec. & laundry. No pets. **Mgmt:** 203-755-0621; 203-470-9808

Condos for rent

WATERBURY 2BR Condo. W/D, $775 & up + sec. Sec 8 ok, No pets. 203-879-4126; 203-577-7516

Houses for rent

WATERBURY single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

Roommates

ROOMMATE WANTED clean, quiet, responsible, West Side of Naug. $900/mo. 860-830-5710,

Rooms

WATERBURY 27 Johnson St, furn room, mens rooming house, sec/clean bldg./ shared bath/ all util & cable inc/$125 wk & up, sec/ref chk req. 203.444.7252

Waterbury East End starting at $125 wk. Shared kit & bath, $400 sec. **Velezis Realty 203-574-7777**

WATERBURY furnished bedroom, $650/month. Utilities included. 203-753-3388

Rooms

WATERBURY FURNISHED ROOM non-smoking.
Call 203-524-6146

WOODBURY rooms for rent, no smoke, call George 203-266-4360

Real Estate For Sale

Houses

PROSPECT 176 Scott Rd to settle estate 3BR, 1.5 bath, garage, level lot, new roof & furnace. Easy access to 84. Low taxes, excel Schools. Asking $190,00. Call 203-233-0518 for Appointment.

Lots for sale

BANTAM LAKE (2) bldg lots on 5 ac priv. community. Tennis, boat, water & sewer incl. 860-868-1256

MIDDLEBURY LAND $87,000 or best, 20.49 acres, parcel ID 7-02-028, Benson Rd, **860-307-3695**

Mobile home

NAUGATUCK spacious 2 BR, 1.5 baths, newly remod. **$32,900** Liberty 860-747-6881 860-940-1204

PROSPECT new 2BR 2 bath easy access thru-out **$87,500** LIBERTY 860-747-6881; 203-592-7641

Commercial

Business for sale
Commercial for sale, lease, rent

Commercial for sale, lease, rent

WATERBURY medical office space 1200sf handicap access great location 203-206-4051

WATERTOWN Prime business location for Lease, two spaces from $750 and up, parking lot attached, Call Nico 203-206-3360

WOLCOTT Hair Salon/Barber Shop for Lease.
Excellent Location, turnkey operation, all equip. incl. Call John for more info 203-509-2939

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

HOT TUB 6 person w/outdoor circuit breaker & wire. Needs cover (approx $300); you haul away Wtby. 203-910-5947

STOVE (white) electric, works great. Call 860-274-0016 after 10:00am.

Lost & found

IMPOUNDED NAUG #112 m, pit bull beagle mix, brown & white Spring St 203-729-4324.

Lost & found

LOST CAT Young M Neut. Tabby, drk gray w/ light gray/tan markings. Lost near Lorann Dr. Naugatuck. 203-623-1318

Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

The Board of Finance and the Board of Councilmen of the City of Torrington will hold a Public Hearing on Monday, May 2, 2016 immediately following the Special Joint Meeting of the Board of Finance and the Board of Councilmen and the two previous public hearings that start at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the proposed 2016-2017 budget (except the school budget).

Copies of the proposed budget will be available at the office of the City Comptroller, and the City Clerk, prior to the hearing.

The public is invited to attend and to submit written or oral comments and questions on the budget.

Dated at Torrington, CT,
this 20th day of April, 2016.

BOARD OF FINANCE
BOARD OF COUNCILMEN
CITY OF TORRINGTON

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

The Planning and Zoning Commission has scheduled a public hearing on the following application on Wednesday, April 27, 2016 at 7:30 p.m. in the City Hall Council Chambers, Room 218, 140 Main Street, Torrington, CT:

a. Special Exception 16-305 and Site Plan 1178

Applicant: Greenstone, LLC
Location: 70 North Street
Proposal: Special Exception for storage of more than 100 cubic yards of earth materials; and site plan for vehicle parking and equipment storage outside of enclosed structure

A copy of the above mentioned proposal is on file in the Land Use Office, Room 324,
City of Torrington, 140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission

Dated in Torrington, CT
this 13th day of April 2016

R-A April 13 & 20, 2016

NOTICE TO CREDITORS
ESTATE OF Marian S. Mezzio, of Naugatuck, AKA Marian Mezzio, AKA Marion Mezzio, (16-00097)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Naugatuck Probate Court, by decree dated March 15, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Chief Clerk

The fiduciary is:
Richard Mezzio
c/o Atty James C. Winters
Winters & Winters
315 Highland Avenue, Suite 102
Cheshire, CT 06410

R-A April 20, 2016

Legals/ Public Notices

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

At its April 13, 2016 meeting, the Planning and Zoning Commission acted on the following applications:

a. Special Exception 16-307
Applicant: The McCall Foundation, Inc.
Location: 417 Prospect Street

Proposal: Group Care Facility, 7 – 12 beds
DECISION: Approved with conditions.

b. Location Approval and Site Plan 1183
Applicant:
CAO Enterprises LLC
Location: 2101 Winsted Road
Proposal: Repairer's license, Location Approval
DECISION: Approved

c. Special Exception 16-308
Applicant: Brian Butler
Location: 478 Norfolk Road
Proposal: Construct residential addition within front yard setback
DECISION: Approved with conditons

d. Zoning Regulations Amendment
Applicant: City of Torrington Planning and Zoning Commission
Proposal: Zoning Regulations, Amendments to Section 7.2, Flood Hazard Regulations

DECISION: Approved.
The effective date of the Zoning Regulation Change shall be April 21, 2016.

Copies of the above applications and plans are on file in the Land Use Office,
City of Torrington,
140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission
Dated in Torrington, CT
this 20th day of April, 2016
R-A April 20, 2016

READY FOR A NEW POSITION?

Check us out in print and online, you'll soon find there's opportunity in the Classifieds!
RepublicanAmerican

Legal Notice
Town of Winchester
Zoning Board of Appeals
Public Hearing

The Town of Winchester Zoning Board of Appeals will hold its meeting. A Public Hearing on April 26th, 2016, 7:00 p.m. in the P. Francis Hicks Room, 2nd floor Town Hall, 338 Main St., Winsted, CT to act on the following:

#16-5167 Request for variance from section 4.2 Frontyard Setback at 65 Oakdale Ave.

Interested parties may appear and be heard.
Dated this 11th day
of April 2016
David Villa, Chairman
Zoning Board of Appeals
R-A April 14 & 20, 2016

Legals/ Public Notices

LEGAL NOTICE
WARNING
ANNUAL TOWN BUDGET MEETING
TOWN OF WINCHESER, CONNECTICUT
Monday, May 2, 2016

Warning to all persons entitled to vote in Town Meetings of the Town of Winchester, County of Litchfield, and the State of Connecticut are hereby notified and warned that the Annual Budget Meeting of said Town will be held in The Gilbert High School Auditorium, 200 Williams Ave., in said Town, on Monday, May 2, 2016 at 7:00 p.m. for the following purpose to Wit:

1). To receive a report of the Board of Selectmen including its estimates of receipts and expenditures and its recommendation in accordance with the law and to take action upon the same and to adopt a budget for the Town for the next Fiscal Year commencing July 1, 2016

2). To take any action proper to come before said meeting.
Dated at Winchester, this April 19, 2016
Received by Sheila S. Sedlack, Town Clerk
RA April 20, 2016

Remodel It Right!
Find Help In The
At Your Service Directory
Every Day In The
RepublicanAmerican
Classifieds!

MOTHER'S DAY CONTEST

OFFICIAL CONTEST RULES

1. Submit your name, address and phone on an official entry blank. Entry form must be completely filled out. No photo copies will be accepted. All entries, dropped off or mailed, must be in a sealed envelope. Enter as often as you like. All entries will be eligible for the Grand Prize drawing.
2. Mail entries to: **MOTHER'S DAY CONTEST, P.O. Box 2000, Waterbury, CT 06722-2000.** Entries must bear proper postage. Only one entry per envelope. No payments or business correspondence should be mailed to this address.
3. No purchase necessary. Entry blanks published daily in the Republican-American *OR* are available at the Republican-American main office located at 389 Meadow Street, Waterbury.
4. All entries must be received by May 6, 2016. Grand prize drawing will be May 6, 2016. Winner will be notified by phone and winner's name will be published in the Republican-American on Sunday, May 10, 2015. Winner must appear in person during the hours of 9am and 5pm within seven business days *(Saturday and Sunday excluded)* from the date they are notified. The Grand Prize winner must be able to provide proper identification with the correct address as it appears on the official winning entry form.
5. Winner is responsible for applicable federal, state and local taxes.
6. Winner automatically permits the use of their name, address and photo for Republican-American promotional purposes.
7. Employees of the Republican-American, TeleReach, Inc. as well as their immediate families, are not eligible.
9. Participants must be 18 years of age or older.
10. Void where prohibited by law.
11. Odds of winning determined by the number of entries received.

Legals/ Public Notices

Notice of Permit Application
Municipality: Waterbury, CT

Notice is hereby given that F&G, LLC (the "applicant") of 15 Mullen Road, Enfield, CT is submitting, to the Department of Energy & Environmental Protection, an application under Connecticut General Statutes Section 22a-208a for a new permit for operation of solid waste facilities. The facility address is 260 Railroad Hill Street, Waterbury, CT.

The existing facility is currently permitted as a Single Item Recycling Facility for acceptance and processing of recyclable materials. The purpose of this new permit is to increase the processing capacity to 700 tons per day and to add the acceptance and transfer of municipal solid waste(MSW), the volume reduction of Construction & Demolition debris, over-sized MSW and non-putrescible MSW, and to accommodate the acceptance, processing and transfer of singlestream recyclable materials in addition of the previously permitted solid waste material (recyclable paper).

Once completed, interested persons may obtain copies of the application from Anchor Engineering Services, Inc, 41 Sequin Drive, Glastonbury, CT 06033, telephone (860) 633-8770, contact T.J. Therriault, at cost.

Once submitted, the application will be available for inspection at the Department of Energy & Environmental Protection, Waste Engineering & Enforcement Division, 79 Elm Street, Hartford, CT 06106-5127, telephone (860) 424-3366, from 8:30 to 4:30 Monday through Friday.

R-A 4/20/16

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
ORDER OF NOTICE

NOTICE TO: Kelli Smith; Mother of female children born on 10-11-07 and 9-14-12 and a male child born on 11-25-03 in town of Waterbury, CT

of parts unknown

A petition has been filed seeking:

Commitment of minor child(ren) of the above named or vesting of custody and care of said Child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.

Hearing on an Order of Temporary Custody will be heard on: 4-22-16 at 11:00 a.m. at SCJM, 7 Kendrick Ave, 3RD Floor, Waterbury, CT 06702.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Waterbury Republican American, a newspaper having a circulation in the town/city of Waterbury, CT

Honorable Joseph W. Doherty
Judge

Renee Polletta, Office Clerk
Date signed 4-15-16

RIGHT TO COUNSEL: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your Hearing is to be held.
R-A April 20, 2016

Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN, that the Board of Councilmen of the City of Torrington will hold a public hearing on Monday, May 2, 2016, immediately following the previous public hearing starting at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the lease of City of Torrington Property located at the Torrington Landfill, 105 Vista Drive in Torrington for the installation of a Solar Array Project. Sketches of the proposed project are available for public review in the City Clerk's Office.

All interested parties are invited to attend and be heard.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20 & 25, 2016

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the Board of Councilmen of the City of Torrington will hold a public hearing in the City Hall Auditorium, 140 Main Street, Torrington, CT, on Monday, May 2, 2016, at 6:30 p.m., with respect to the following proposed resolution:

Resolution Authorizing An Appropriation Of $4,100,000 For The East Basin Sewer Rehabilitation Project And The Financing of Said Appropriation By The Issuance Of Revenue Bonds, Notes And Obligations Of The City In An Amount Not To Exceed $4,100,000.

The full text of the proposed resolution is on file, and open to public in inspection, in the office of the City Clerk, 140 Main Street, Torrington, CT.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

Legals/ Public Notices

NOTICE OF WARNING OF DISTRICT MEETING

All electors and citizens who are qualified to vote in town meetings of the Towns of Bethlehem and Woodbury, Connecticut, are hereby notified and warned that a District Meeting of Regional School District 14 will be held in the library of Nonnewaug High School, 5 Minortown Road, Woodbury, Connecticut, on Monday, May 2, 2016 at 7:30 p.m.PURPOSE: TO CONSIDER THE BUDGET SUBMITTED BY THE BOARD OF EDUCATION FOR REGIONAL SCHOOL DISTRICT NO. 14 FOR THE FISCAL YEAR COMMENCING JULY 1, 2016 AND ENDING JUNE 30, 2017 IN THE AMOUNT OF $ 33,154,406.The vote on said budget will be by the voting machines in the towns of Bethlehem and Woodbury, Connecticut on Tuesday, May 3, 2016, between the hours of 6:00 a.m. and 8:00 p.m., the day following the District Meeting.
BOARD OF EDUCATION
REGIONAL SCHOOL DISTRICT NO. 14
Bethlehem and Woodbury, Connecticut
BY: George Bauer, Chairperson
RA 4/20/2016

TOWN OF LITCHFIELD
NOTICE OF PUBLIC HEARING OF THE BOARD OF FINANCE

The Board of Finance of the Town of Litchfield will hold a Public Hearing at the Litchfield Intermediate School Auditorium on Wednesday, April 27, 2016 at 7:00 p.m., at which itemized estimates of expenditures of the Town for the ensuing fiscal year shall be presented and at which all persons shall be heard in regard to any appropriation which they are desirous that the Board should recommend or reject.

Dated at Litchfield, Connecticut, this 11th day of April, 2016.

Helen RuwetBunnell
Anne Dranginis
Mitchell Fishman
Edward Gadomski
David W. Geiger
David W. Wilson

Board of Finance
Town of Litchfield
RA April 20, 2016

Office of Health Care Access Public Hearings

Statute Reference: 19a-638
Applicant(s): Saint Mary's Health System Inc.
Trinity Health Inc.
Town: Waterbury
Docket Number: 15-32045-CON
Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.
Date: May 9, 2016
Time: 3:00 p.m.
Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.
R-A April 20, 2016

NOTICE

Pursuant to General Statutes § 16-50p (a), the Connecticut Siting Council (Council) announces that, on April 14, 2016, the Council issued Findings of Fact, an Opinion, and a Decision and Order approving an application from The Connecticut Light & Power Company d/b/a Eversource Energy for a Certificate of Environmental Compatibility and Public Need for the Frost Bridge to Campville 115-kilovolt (kV) electric transmission line project that traverses the municipalities of Watertown, Thomaston, Litchfield, and Harwinton, which consists of (a) construction, maintenance and operation of a new 115-kV overhead electric transmission line entirely within existing Eversource right-of-way and associated facilities extending approximately 10.4 miles between Eversource's existing Frost Bridge Substation in the Town of Watertown and existing Campville Substation in the Town of Harwinton; (b) related modifications to Frost Bridge Substation and Campville Substation; and (c) reconfiguration of a 0.4 mile segment of two existing 115-kV electric transmission lines across the Naugatuck River in the Towns of Litchfield and Harwinton within the same existing right-of-way as the new 115-kV electric transmission line. This application record is available for public inspection in the Council's office, Ten Franklin Square, New Britain, Connecticut. 4/20/2016

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Henry's Appliance Repair We service all major brands & offer used appliances 203-632-8000

Asphalt paving

BRASS PAVING LLC ~ CT#575141 Paving driveways, sealing & repairs. Free est. 203-574-2693

MARINI PAVING 860-274-3978
* Driveways * Repairs
* Seal Coating * Drainage
#563045. 203-410-9226

SPINO'S PAVING
Comm'l and resid'l driveways, parking areas, plow damage repair and curbing replaced. Free estimates. Ct Lic #579761.
203-574-2547 cell 203-537-3151

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One call for all your pavement needs! Visit us online to learn the 7 secrets for choosing a paving contractor CT# 612743. Call 860-945-0873 Visit Deziel Paving on Facebook to view our current project.

Carpentry

DN Carpentry Window, doors, decks, baths, drywall, trim, paint, fin.bsmt. #614783, Ins. 203 233 0795

Electrical

Accurate Electrical
Fully insured, Lic. E1-189172
203-509-7027

DW ELECTRICAL Any size jobs, srvc grounding, upgrades, rem. Free est #182995. 203-592-3562

General services

EMT PROGRAMS Starting in May. For info call/email 203-632-9247 or mededstaff@mededct.com

Gutters

BAY KLEEN Gutter cleaning & repair, powerwashing homes & decks 203-525-3890. #0643703

PEET SEAMLESS GUTTERS & SERVICES
860-283-2292

Hauling services

ALL ABOUT SERVICE
S&P CARTING trash & cleanup 10-40 yard roll off containers. Same day svc. Ins V/MC **203-755-4656**

JAY & EDDIE
Junk removal & Lawncare.
Call 203-558-0488

JUNK REMOVAL furn., appliances, shed, attic, basement, piano removal, Spring cleanup, 20% off, 203-535-9817, 860-575-8218

Home improvement

BUDGET PAINTING & Remod roofs, siding & painting, fully insured #0638113. Call 203-982-5353

DREAM DECKS by Advance Contrsuction of CT 100% Financing, no money down 30 yrs exp. #0644836. 203-788-3799

PREMIER SERVICES kit bths decks ceramic tile siding roofing fully ins fr est lic. 641592. **203-228-3750**

Landscaping & lawns

ALL LAWNCARE
Spring has sprung. Spring cleaup, weekly lawn maint. All aspects of landscaping. Irrigation PLM0277997-P1. Fertlization program B2008. 203-755-4656

B&D LANDSCAPING landscaping, mowing, cleanups, trimming, com & res. #540877. Call 203-575-9282, 203-437-1641

BUD'S LAWN CARE cleanups, mowing, pruning, etc. FR. EST. Lic. #0645023; 203-558-9503

CREST LAWN SERVICES
mowing, and more. Reas. rates. Veteran. 203-509-6395

DB LANDSCAPE Lawn mowing Commr'l & Residential, mulching, trimming, stone work, free estimate, #0633401; 203-704-1640

SCREENED LOAM DARK, RICH FARM LOAM. PICKED UP OR DELIVERED. **203-879-2731**

Landscaping & lawns

Spring Cleanups/Property Maint. Weekly cut. East Mtn., Prospect, Naugatuck areas. 203-232-6342

Masonry

A-1 JIMMY'S MASONRY #604550. Walls, brick/ blue stone, steps, sidewalks, repairs & more. Free est. 203-982-0145/860-628-0455

ALFRED MASONRY 30+yr exp. Pools, deck, stamp conc, patios, retain. walls, stucco Ins #565904. Free est. Call 860-274-7977

BELULI MASONRY
Stone walls, fireplaces; Any size job; 203-695-8177; #HIC0565123

EXCEPTIONAL MASONRY
Pavers, stonework, chimneys, waterproofing, repairs, free estimates 0638978. 860-922-8922

F&R Masonry Walls, Patios, steps, walks, chimney, repairs, etc. *Free Est.* #0637257 ins. **203-805-9114**

FINELINE MASONRY Stamped Concrete,Patios,Walkways,Stonewalls, #0640314; 860-378-5877

JIMMY MASONRY Masonry stone, brick, steps, sidewalks, stone walls etc. #0639219. 203-808-0816

KONSTANDING MASONRY Stone pavers, steps, Patios, Chimney, repairs & more. Call 203-528-8294

PAUL'S MASONRY
Stone, brick, block, walks, chimneys, patios, FP's, etc. free est. #624168. 203-706-9281

Moving

DON'S * MOVING
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PUBLIC NOTICE OF INTENTION NOT TO PREPARE AN ENVIRONMENTAL IMPACT EVALUATION

A. PROJECT IDENTIFICATION
Project Name: Town of Salisbury, Preliminary Engineering Report I/I and Biological Nutrient Removal Water Pollution Control Facilities

Project Location: Lakeville and Salisbury Village Sewered Areas, Salisbury WPCF located at the end of Walton Street in the Village of Lakeville

1. Project Description:

The Town of Salisbury is proposing sanitary sewer rehabilitation and WPCF improvements to address the excessive infiltration and inflow (I/I) entering the old sanitary sewers and manholes, and achieve phosphorus reductions in the treated effluent wastewater in order to meet current and future NPDES permit limits. The existing wastewater collection and treatment system provides sanitary sewer service to both the villages of Salisbury and Lakeville. Although the town has not experienced significant population growth, many of the existing sanitary sewers and manholes located in the Village of Lakeville, which date back to the early 1900's, continue to age considerably and the regulatory environment has changed with respect to phosphorus reductions. I/I has been identified as a significant problem primarily in the Lakeville Village area. It is anticipated that through this effort, the town will be able to reduce sources of excessive I/I through proposed sanitary sewer rehabilitation by means of cleaning and lining of older existing sanitary sewers and the restoration of sanitary manholes. The elimination of excessive I/I along with the proposed WPCF improvements will also further reduce phosphorus concentrations through the implementation of a chemical feed system that will achieve reductions in the total phosphorus concentrations in the treated effluent. Proposed upgrades will not result in a footprint expansion of the sewer lines or an increase in hydraulic capacity of the WPCF.

2. General Information:

The Commissioner of Energy and Environmental Protection is required to ensure that the requirements of the Connecticut Environmental Policy Act (Section 22a-1 of the Connecticut General Statues, CGS) have been met pursuant to CGS Section 22a-482 and regulations adopted thereunder. Based upon the limited nature of this project, and the environmental benefits to be realized, staff has recommended that preparation of an Environmental Impact Evaluation is not warranted.

In accordance with Sec. 22a-482-3(a)(4)(A) of the Regulations of Connecticut State Agencies, this notice of intent not to prepare an Environmental Impact Evaluation is being published. Interested persons who wish to submit comments and/or obtain more information, including inspection of supporting documentation may do so by contacting Max Fan, between the hours of 8:00 a.m. and 3:30 p.m., Monday through Friday at (860) 424-3670. Written comments will be accepted for 30 days from the publication date and should be sent to the attention of the above contact person, Bureau of Water Protection and Land Reuse, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106-5127.

/s/Betsey Wingfield, Bureau Chief
Bureau of Water Protection and Land Reuse
Dated: 4/19/2016
R-A April 20, 2016

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, April 22, 2016 11:22 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
Subject: 15-32045-CON Request for Prefile Testimony
Attachments: 15-32045 Saint Mary Issues & Request for Pre-File.pdf

Dear Mr. Hartley and Mr. Anthony,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 63 Grand Street, Waterbury, CT. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

ISSUES

Office of Health Care Access Docket Number: 15-32045-CON

The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:

1. The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.

2. The development of a plan to adequately fund Saint Mary's pension liabilities.

3. The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.

4. Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.

5. Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.

Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:

1. Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.

2. Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.

3. Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)

4. The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany

fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.

5. Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.

Trinity Health New England – Affiliated Hospitals	Capital Commitment (current)	Capital Commitment If Saint Mary's attains 8% cash flow margin
Saint Mary's	$	$
Johnson Memorial	$	$
St. Francis Hospital	$	$
Total	$	$

6. For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:

Source of Funding	Saint Mary's	Johnson	St. Francis
Routine Capital Expenditures	$	$	$
Operating/Non-Operating Income	$	$	$
Capital Contribution-Trinity	$	$	$
Other	$	$	$

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Friday, April 22, 2016 11:41 AM
To: Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA; Rotavera, Liz; Joe Connolly (JConnolly@Stmh.org); Attorney Bob Anthony (BAnthony@Stmh.org)
Subject: RE: 15-32045-CON Request for Prefile Testimony

Thank you

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Friday, April 22, 2016 11:22 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
Subject: 15-32045-CON Request for Prefile Testimony

Dear Mr. Hartley and Mr. Anthony,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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User, OHCA

From: Schaeffer-Helmecki, Jessica
Sent: Wednesday, April 27, 2016 8:20 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: 15-32045-CON Order of Admin Notice
Attachments: 15-32045 Admin Notice.pdf

Good Morning Mr. Hartley and Mr. Anthony,

Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075 | F: (860) 418-7053 | E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

Docket No: 15-32045-CON

April 27, 2016

In re: Saint Mary's Health System and Trinity Health – New England, Inc.

ORDER REGARDING ADMINISTRATIVE NOTICE

The Office of Health Care Access, for purposes of analyzing and rendering a decision in the application filed under Docket Number 15-32045-CON, is hereby taking administrative notice of:

a) ***In re Saint Francis Care, Inc. and Trinity Health Corporation, Inc.***, Docket No. 15-31979-CON:
- Exhibit D, Completeness Responses, pp. 635-37
- Exhibit J, Prefiled Testimony, p. 789
- Exhibit M, Hearing Transcript, pp. 23-35, and

b) ***In re Johnson Memorial Medical Center and Trinity Health New England.***, Docket No. 15-32002-CON:
- Exhibit A, CON Application, pp. 24, 71
- Exhibit D, Completeness Responses, p. 1974

Kevin Hansted

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Connecticut Department of Public Health

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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Greer, Leslie

From: Attorney Bob Anthony <BAnthony@Stmh.org>
Sent: Wednesday, April 27, 2016 10:36 AM
To: Schaeffer-Helmecki, Jessica; Hartley, Christopher
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: RE: 15-32045-CON Order of Admin Notice

Thank you.

Bob Anthony

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Wednesday, April 27, 2016 8:20 AM
To: Hartley, Christopher; Attorney Bob Anthony
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: 15-32045-CON Order of Admin Notice

Good Morning Mr. Hartley and Mr. Anthony,

Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
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Saint Mary's Health System Disclaimer:

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Saint Mary's
HOSPITAL

May 3, 2016

Via Email and Hand Delivery

Jessica Schaeffer – Helmecki, JD, MPA
Planning Analyst
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Responses to Interrogatories and Pre-File Testimonies for the Certificate of Need Application for Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer- Helmecki:

Enclosed please find our responses to OHCA's April 22, 2016 letter regarding the above-referenced Certificate of Need application in both pdf and word formats submitted via email and one copy hand delivered.

If you have any questions regarding this response, please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573 or Bob Anthony, General Counsel at 203-709-6447.

Sincerely,

By: _____
R. Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Saint Francis Hospital and Medical Center

By: _____
Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.

Enclosures

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 63 Grand Street, Waterbury, CT. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

Phone: (860) 418-7001 • Fax: (860) 418-7053
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

ISSUES

Office of Health Care Access Docket Number: 15-32045-CON

The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:

1. **The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.**

   As noted on page 865 of the application, Trinity Health and Trinity Health – New England, Inc. will commit to ensure the expenditure of up to $100 million in Capital Expenditures to support the operations and strategic initiatives of Saint Mary's Hospital and Saint Mary's controlled subsidiaries. While a significant portion of the Capital Expenditures are anticipated to be for facilities, equipment and information technology as discussed on page 869 of the application, a portion of this commitment may be available to support strategic growth and enhancement of healthcare services to better serve the community within the Waterbury area.

   In terms of the financial feasibility of the proposal, cash flow from operations for Saint Francis and its controlled subsidiaries was $33.6 million for the last 12 month ended March 31, 2016. In addition, Saint Mary's and its controlled subsidiaries had cash flow from operations for the same period of$11.8 million. Based the Saint Mary's financial projections noted in Financial Worksheet A, Saint Mary's and it's controlled subsidiaries are expected to have positive cash flow from operations (less annual debt service payments) of $13.3, $15.6 and $18.1 million for the years ended September 30, 2016, 2017 and 2018. Based on the projected cash flow margins for the two organizations, it is anticipated that a portion of the funding for the capital commitment will be available from operations and any shortfall will be available through the Trinity Health debt program through Trinity Health –New England, Inc. (refer to Table in question #6 below). Also, see list of sources of funding at page 866 question #7. Lastly, Trinity Health's strong credit rating as noted on page 871, question #14, will allow continued access to capital for strategic investments which are aligned with the strategic plan.

2. **The development of a plan to adequately fund Saint Mary's pension liabilities.**

   As noted on page 870 of the application, Saint Mary's pension plan is currently underfunded and its funding status as of September 30, 2015 was 48%. Trinity Health's funded status for its defined benefit plans was 85% as of June 30, 2015. As noted on page 83 of the original application, the applicants will develop a plan to ensure Saint Mary's ability to make annual pension payments to the plan beneficiaries.

3. The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.

In March 2015, Saint Mary's obtained a $15.0 million bank loan. The bank loan has a five year term with $250,000 principal due each month and corresponding interest at the current LIBOR rate plus 110 basis points. The loan matures in February 2020. Saint Mary's is required to comply with certain financial covenants including a debt service coverage ratio of 1:25. It is expected that Trinity Health and Trinity Health – New England, Inc. would refinance Saint Mary's external debt with an inter-company loan post-closing. This is advantageous to Saint Mary's as it would eliminate current required debt covenant compliance at the local level.

See **Exhibit A** attached for description of Trinity Health's intercompany loan program and the process for accessing funds.

4. Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.

As stated on Page 22 of the application, joining Trinity Health-New England, Inc. will assist Saint Mary's in addressing the various demands created by the 2010 Patient Protection and Affordable Care Act (PPACA) including:

- Identification and development of new models of providing care
- The increased cost associated with quality improvements
- Physician partnerships
- Clinical service redesign
- Electronic medical records development
- Strategic alignments to form an integrated organization
- Meeting the needs of aging infrastructure and addressing the health service needs of the Waterbury community as identified in the Community Needs Assessment (see pages 189-261).

New Models of Providing Care

As noted on Page 622 of the application ". . . Trinity Health is intently focused on the delivery of high value Triple Aim outcomes that improve the health of those it serves, reduce the per capita cost of delivery care, and improve the quality of care and satisfaction of our patients . . . "Trinity Health's people-centered 2020 strategy is focused on its population health journey to improve the health of its communities and the experience of care for patients. Trinity Health's strategy is to build a people-centered health system in which the people it serves are placed at the center of every behavior, action and decision in the Trinity Health system.

Ultimately, the patients and their families who use Saint Mary's Health System, Inc., including Saint Mary's Hospital, will be able to move among the Trinity Health New England, Inc.'s facilities using a single medical record and be treated by a group of physicians and other health professionals that use a common set of clinical protocols. The goal of Trinity Health-New England, Inc. is to meet the Triple Aim objectives for each person's care. The goal would be for Trinity-Health-New England, Inc. will sign contracts with insurance programs covering the cost of care of these patients that will be based on per capita payment structures that support using the best site for individual care delivery once they exist. Trinity Health's group purchasing power, access to needed capital and the overall credit strength of Trinity Health will support the necessary changes needed to implement these new models of care for all parts of Trinity Health-New England including Saint Mary's Hospital and Health System.

Increased Cost Associated with Quality Improvements

Pages 622-624 of the application describe Trinity Health's ". . . Unified Clinical Organization (UCO) which provides a data and evidenced-based infrastructure for clinicians across the Trinity Health system to advance a culture of safety and high reliability . . . " led by clinicians, the UCO has promoted a wide range of system wide safety initiatives (see Page 623) which will be incorporated by Saint Mary's clinicians in their future patient interactions.

Saint Mary's clinicians will also participate in Trinity Health sponsored clinical conferences that feature recognized industry leading professionals and focus on proven methods to reduce costs, improve safety and quality. Access to this type of quality enhancement system would be too costly for a single hospital or system to provide its clinical staff on a routine basis.

In addition, as noted on Pages 262-282 on the application, Trinity Health-New England, Inc. has formed a series of clinical service lines which have a proven track record of success in the areas of quality and service excellence. Saint Mary's Hospital and Health System will become a vital member of these service lines as part of Trinity Health-New England, Inc.

Physician Partnerships

First and foremost, physicians are attracted to organizations that place the care of the patient first and are dedicated to meeting the highest standards of health care delivery. The commitment to quality care for patients by both Trinity Health and Trinity Health-New England, Inc. has been described previously. Both organizations will also address the new era of risk/value based contracts represented by the changes initiated by the PPACA, while still supporting the long standing commitment of Saint Mary's to education of physicians and other allied health professionals, a critical need for a state with an aging group of health care providers to match the aging of its population.

Furthermore, the scale of both Trinity Health and Trinity Health-New England, Inc. provide a recruiting infrastructure for health professionals and access to clinical collaboration that is second to none in the region and the country as a whole.

Clinical Service Redesign

Though covered previously, both Trinity Health UCO and Trinity Health-New England, Inc.'s Institute for Primary Care Innovation demonstrates both organizations' commitment to encourage innovation and the development and application of the latest clinical techniques to the treatment of patients. The purpose of clinical service readiness is to provide the right care in the right place at the right time. The population based approach to care management supported by Trinity Health seeks to keep people healthy and use an outpatient based approach whenever appropriate for care delivery.

Strategic Alignments to Form an Integrated Organization

As stated on Page 20 of the application ". . . Trinity Health has created an internal development team, charged with growth and strategic positioning of the system. Two of Trinity Health's key growth initiatives aim to extend and strengthen the Catholic healthcare mission of the organization through alignment with other organizations and to expand the system footprint to create an integrated accountable care organization (ACO) in every one of its mandates . . . "

Saint Mary's believes entering into a partnership with Trinity Health-New England, Inc. will join its organization to a strong regional Catholic system that already had an ACO and an electronic medical record as well as an established affiliation relationship with substantial post-acute care group of providers. This approach will be duplicated in the Waterbury market.

Trinity Health has indicated its willingness to support the strategic capital investment required by Trinity Health-New England, Inc. to support the strategic alignment needs of Saint Mary's Hospital and Health

Meeting the Needs of an Aging Infrastructure and the Need to Provide the Health Services the Community of Waterbury Requires, as Reflected in the Community Needs Assessment.

Pages 21-22, 31, 47, 82, 869 & 870 of the application make reference to the need for facility improvements, acquisition of new and replacement equipment and the purchase of a new electronic medical record. There is a 5 year capital need identified that includes:

	$ in Millions
• Hospital facility upgrades - – Primary backup generators – Electric power switching gears – 2 chillers – 3 elevators and several air handling units	$30

– Nursing unit upgrades – Upgrades and renovations	
• Replacement of clinical equipment – – Operating room refurbishing – Upgraded breast imaging equipment – Private patient room conversion	$18
• Information technology upgrades and electronic health record	$12
• Urgent Care/ambulatory Care	$10
• Ambulatory pavilion on campus -	$25
• Clinically integrated network development	$5
Total	$100

These categories add up to $100 million. Once Saint Mary's Hospital & Health System becomes part of Trinity Health-New England, Inc., additional detail will be developed as part of the Trinity Health annual capital expenditure budget designed to address these capital needs. As identified on Page 867 projects in excess of $5 million and $25 million must be approved by Trinity Health before Saint Mary's can spend the funds. Both Trinity Health and Trinity Health-New England will bring corporate resources in purchasing, construction planning and design and the financing of individual projects as needed. The approved capital expenditures will be part of the $100 million capital planned for Saint Mary's. Capital projects from the approved capital list will be identified and implemented in each fiscal year over the 5 year period. In some cases, projects that require multiple years will be identified within each annual capital budget cycle.

For more details on capital commitment for Saint Mary's and the rest of Trinity Health-New England, please refer to Question #s 5 & 6 of this document. With regard to the Waterbury Community Needs Assessment please refer to the answer to Issue #5 of this document.

5. **Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.**

On pages 189-261 (Exhibit 6) of the CON application contains the Community Needs Assessment for Waterbury completed by the Greater Waterbury Health Improvement Partnership ("GWHIP").

This Plan outlines key health statistics for the Waterbury area and identifies the challenges to keeping the population healthy. Mental health and substance abuse, obesity and tobacco usage were ranked very high in this report, and were used as the basis for organizing the work groups of the partnership.

Saint Mary's continues to play an active role in the Greater Waterbury Health Improvement Partnership (GWHIP). We have funded activities of the partnership, and play an active role in the steering committee. In addition to the work plans contained in the original document, several areas of focus have been identified. These include:

- Establishing a committee focused on asthma, with the express purpose of coordinating the activities of existing community programs such as Putting on AIRS and Easy Breathing. The formation of this workgroup is in consistent with Saint Mary's participation in the Connecticut Hospital Association's Asthma initiative. According to their website, "The goals of CHA's Statewide Asthma Initiative are to improve access and appropriate care by partnering with the community; reduce asthma hospitalizations and ED visits; and significantly advance progress toward health equity for asthma care and outcomes by 2017." Saint Mary's is an active participant in these activities.
- Supporting the formation of a Community Care Team (CCT) as part of our focus on improving mental health and substance abuse services. The CCT is a model that has been successfully implemented in other cities throughout the state. The Waterbury program, as proposed, will be financially supported through GWHIP partners and will employ a coordinator to provide administrative support for various providers to actively case manage high-frequency emergency department patients.
- Maintaining our focus on obesity, with an emphasis on establishing Healthy Corner Stores. This initiative is focused on making healthy food options available in low-income neighborhoods that have been designated as "food deserts."
- Establish a marketing and communications workgroup to more effectively communicate the resources available within our community.

By becoming a member of Trinity Health – New England, Inc. Saint Mary's will be able to strengthen its already considerable commitment to community health and preventative care services. As stated in the CON, Trinity's "Healthy People 2020" initiative is in alignment with and compliments Saint Mary's current efforts in community health initiatives.

With regard to unmet health needs, Trinity Health has a national initiative known as the "Community Health and Well-Being" strategy that focuses on three major health goals:

Goal 1: Reduce the number of people who are uninsured in our communities.

Goal 2: Prioritize obesity prevention and tobacco control and;

Goal 3: Transform safety net care

These system wide goals have deliverables that are specific, measurable, attainable, relevant and time bonded and all Regional Health Ministries are participants in achieving these goals.

Goal 1 Objective - In partnership with community organizations each regional health ministry (RHM) will host or co-lead 10 enrollment activities targeted at reaching a total of 5% of the eligible population in the RHM's market.

In an effort to achieve this objective each RHM is an active participant in the annual open enrollment efforts of each State Health Exchange.

Goal 2 Objective – Develop a tobacco and obesity prevention portfolio

This portfolio is aimed at supporting healthy choices in RHM communities including tobacco free living, physical activity and healthy eating.

This support includes forming community coalitions and changing institutional policies where necessary to ensure greater support for healthy communities. One example of the steps being taken in this area include Trinity Health's national and state efforts to move the legal minimum age for cigarette purchases to 21 (Tobacco 21).

Goal 3 Objective- Seeks to improve the health of seniors 65 years and older who are dually eligible for Medicare and Medicaid

The dually eligible elderly represent some of the poorest and sickest individuals. Working with Trinity Health each RHM will develop best care practices and innovations aimed at encouraging alternate care models and/or risk contracting initiatives focused on this population. Whenever possible these initiatives will include external partners from the community.

To support this initiative all members of Trinity Health have access to Trinity Health's central office resources including:

- A Data Mart containing a large array of data from many sources addressing needs and services used by dually eligible elderly.
- Summary of promising best practices for clinical integration.
- Turn key delivery tool kits.

Clearly by becoming a part of Trinity Health - New England Inc., a great deal of additional resources will be available to Saint Mary's in its efforts to improve health of the Waterbury community.

In addition to these Trinity Health system wide initiatives Saint Mary' s will also be integrated with the health needs strategies identified by Trinity Health – New England, Inc. through its own 2016 Community Needs Assessment (CHNA) and Strategic Implementation Plan (SIP). At present this CHNA is scheduled for completion on 6/30/16 and the SIP on 11/15/16. Once Saint Mary's Hospital and Health System joins Trinity Health - New England, Inc. its Data Haven survey

data will be reviewed and the priorities of the Trinity Health - New England, Inc. Strategic Implementation Plan will be adjusted to reflect this data where necessary.

Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:

1. **Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.**

   There is no distinction between Trinity Health-New England, Inc. (the formal legal name registered with the Connecticut Secretary of State) and the New England Regional Health Ministry (the abbreviated reference to the legal entity).

2. **Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.**

   See **Exhibit B** (note due to timing, YTD actual results were provided through March 31, 2016)

3. **Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)**

   See **Exhibit C** (note due to timing, YTD Financial Measurement Indicators were provided through March 31, 2016)

4. **The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.**

   As noted on page 1016 of the certificate of need application, the system office allocation is at the Regional Health Ministry level. Therefore, Trinity Health – New England will be charged these system office fees. Trinity Health – New England will then allocate the system fees to each organization within the regional health ministry based on at least two factors (size of the

organization and the status of utilization of system resources). The utilization of system office resources and further integration among the hospitals within Trinity Health – New England, Inc. should ultimately decrease local expenses. For example, if external audit and consulting firms are being utilized to prepare tax returns and other analysis, the system office resources including the tax department and internal consultants will be available to provide these services. Furthermore, as noted on page 1016, it is expected that the system office allocation will decrease as Trinity Health – New England, Inc. become more efficient through integration across the various hospital/systems.

5. **Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.**

Trinity Health New England – Affiliated Hospitals	Capital Commitment (current)	Capital Commitment If Saint Mary's attains 8% cash flow margin
Saint Mary's	$100 million	$120 million
Johnson Memorial	$ 13 million	$13 million
St. Francis Hospital	$162 million	$142 million
Total	$275 million	$275 million

As previously noted, this is the **minimum** capital commitment for each of the respective organizations and their affiliated entities. In addition, the allocation of the $275 million Capital Commitment as noted on page 1017 of the original CON and on page 635 of the Saint Francis CON will be based on strategic priorities of the collective organizations. "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development."

6. **For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:**

Source of Funding	Saint Mary's	Johnson	Saint. Francis
Total Capital Expenditures (Capital Commitment)	$100.0 million	$13.0 million	$162.0 million
Operating Income (Minimum from operations for capital is to fund annual deprecation)[1]	$45.3	$5.6	$158.0
Trinity Health (intercompany loan and/or capital contribution)	$54.7	$7.4	$ 4.0
Other	$n/a	$n/a	$n/a

As noted in the response to question #1 above, the goal of Trinity Health – New England is to fund the $275 million total Capital Commitment for the region through cash flow from operations. The preliminary budget for FY 2017 for the Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. Therefore, if such target is not achieved, the allocation necessary from Trinity Health may increase. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. The allocation by source of funding is preliminary based on current operating performance and could change based on future operating cash flows.

As noted in the response to question #1 above, the goal of each of the hospitals/systems is to fund the majority of the capital expenditure through current operations. The preliminary budget for FY 2017 for Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. Further allocation of the source of funding by category by entity for these respective five year commitments are not known at this time.

[1] Estimated based on current annual depreciation less principal debt payments

EXHIBIT A

Exhibit A

Trinity Health Inter-Company Loan Program (the "Program")

Program Description

Under the Program, Trinity Health is the primary obligor on all existing tax-exempt debt issued by Trinity Health or its predecessor organizations. All tax-exempt debt is issued by Trinity Health under the Trinity Health Master Trust Indenture. Long-term debt of Regional Health Ministries (RHMs) is coordinated by Trinity Health and funded internally through loans from the Program.

Background and Program Characteristics

- Ensures all RHMs borrow at the same rate
- Enables the financing of projects in states with the lowest all-in borrowing costs through composite bond issues, typically on an annual basis
- Maximizes the life of the debt and minimizes annual debt service requirements
- Proceeds from annual composite bond issues are used to replenish the Program fund
- Proceeds from Inter-Company Loans (ICLs) are used to:
    - Replenish cash spent on capital expenditures
    - Offset annual increase in operating expenses to maintain days cash on hand
    - Fund the amortization of debt

Process for Issuing Inter-Company Loans

Each year during the Strategic Financial Planning process, the appropriate amount of debt and cash for each RHM is determined. This is further refined during the annual Budget process.

- The total budgeted amount to be borrowed by each RHM is calendarized and System Office Treasury provides rate and monthly interest expense schedules to include in the budget
- Treasury will receive final approved budgets which will indicate, by RHM and month, the amount to be borrowed during the fiscal year
- Per the approved budget, Treasury initiates transfers to the respective RHM operating accounts on the first business day of each month

- Treasury initiates sweep transactions for interest, principal and swap charges each month

Standard Program Procedures

- Calculation of Program Effective Interest Rate (the "Sweep Rate") *
    - Forecast interest rates
        - Obtain LIBOR and SIFMA rates projection from independent third party sources
        - Determine external interest expense for total indebtedness
    - Determine cost of debt administration
        - External interest expense
        - Commercial Paper fees
        - Trustee, legal and finance authorities' service fees
        - Swap settlements
    - Set rates for budget period for interest and swap payments
        - The Sweep Rate will be assessed to each participant based on their total intercompany loan balance outstanding
- Periodic Adjustments to RHM Sweep Rate (if necessary)
    - Notice of rate change to RHMs
    - Analysis of impact to operating income and budget
    - Prepare updated amortization schedules
- New ICLs
    - Develop recommendation for proposed loan via budgeting process
    - Prepare loan documentation, including RHM Promissory Note
    - Coordinate and initiate loan(s) according to budget schedule on first day of each month
- Collection of ICL Debt Service
    - Distribute updated amortization schedules
    - Initiate mid-month cash sweep
    - Coordinate accounting records
- Impact of New Bond Issues
    - Incorporate new debt into Cost of Capital schedule
    - Calculate revised budget rates

**Includes Cost of Trinity Health Swap Program*

Debt Refinancing and Refunding

- In addition to the replenishment of Program funds, the annual composite bond issue also provides an opportunity to refund tax-exempt bonds
- Existing Trinity Health tax-exempt bonds are continuously monitored and analyzed to determine if there is sufficient economic benefit to refund
- In conjunction with the acquisition of a new affiliate, the entity typically enters into the Trinity Health Credit Group as a Designated Affiliate under the Trinity Health Master Trust Indenture
- To the extent allowable under existing documents, the debt of the new affiliate is defeased or redeemed through an Inter-Company Loan from the Program (the underlying bonds may be refunded through the annual composite issue or through the Trinity Health Commercial Paper Program as an interim/bridge financing until the next appropriate composite issue

EXHIBIT B

(YTD) actual results for
Saint Mary's Health System, Saint Mary's Hospital and
TH-NE

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 YTD March W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$832,217	$454,966		$454,966			$0	$0		$0	$0		$0
2	Less: Allowances	$535,300	$297,452		$297,452			$0	$0		$0	$0		$0
3	Less: Charity Care	$1,854	$855		$855			$0	$0		$0	$0		$0
4	Less: Other Deductions	$4,738	$6,348		$6,348			$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$290,325**	**$150,311**	**$0**	**$150,311**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$111,548	$57,719		$57,719	$0		$0	$0		$0	$0		$0
6	Medicaid	$53,959	$26,455		$26,455	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$225	$1,052		$1,052	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$165,732**	**$85,226**	**$0**	**$85,226**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$104,937	$55,014		$55,014	$0		$0	$0		$0	$0		$0
10	Uninsured	$9,669	$4,960		$4,960	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,834	$4,509		$4,509	$0		$0	$0		$0	$0		$0
13	Other	$1,153	$601		$601	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$124,593**	**$65,085**	**$0**	**$65,085**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$290,325**	**$150,311**	**$0**	**$150,311**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$9,675	$5,798		**$5,798**			**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$280,650**	**$144,513**	**$0**	**$144,513**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$9,339	$5,288		**$5,288**			**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$733	$320		**$320**			**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$290,722**	**$150,121**	**$0**	**$150,121**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$123,197	$64,454		$64,454			$0	$0		$0	$0		$0
2	Fringe Benefits	$32,298	$16,909		$16,909			$0	$0		$0	$0		$0
3	Physicians Fees	$9,915	$5,467		$5,467			$0	$0		$0	$0		$0
4	Supplies and Drugs	$47,026	$22,832		$22,832		$0	$0	$0	$0	$0	$0	$0	$0
5	Depreciation and Amortization	$11,636	$6,107		$6,107			$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]				$0			$0	$0		$0	$0		$0
7	Interest Expense	$980	$128		$128			$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$5,572	$3,343		$3,343			$0	$0		$0	$0		$0
9	Lease Expense				$0			$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,937	$27,185		$27,185		$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING EXPENSES	**$288,561**	**$146,425**	**$0**	**$146,425**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$2,161**	**$3,696**	**$0**	**$3,696**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE	**$2,528**	**$503**		**$503**			**$0**	**$0**		**$0**	**$0**		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$4,689**	**$4,199**	**$0**	**$4,199**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments	**$3,000**	$1,500		**$1,500**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.7%**	**2.5%**	**0.0%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**YTD March**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
2	Hospital Non Operating Margin	**0.9%**	**0.3%**	**0.0%**	**0.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**1.6%**	**2.8%**	**0.0%**	**2.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**	**1,680**	1,691		**1,691**			**0**			**0**			**0**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	11,847	5,833		**5,833**			**0**			**0**			**0**
2	Outpatient Visits	238,522	125,267		**125,267**			**0**	0		**0**	0		**0**
	TOTAL VOLUME	**250,369**	**131,100**	**0**	**131,100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	YTD March	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$746,752	$406,827		$406,827			$0	$0		$0	$0		$0
2	Less: Allowances	$484,797	$268,852		$268,852			$0	$0		$0	$0		$0
3	Less: Charity Care	$1,854	$855		$855			$0	$0		$0	$0		$0
4	Less: Other Deductions	$4,738	$6,348		$6,348			$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$255,363**	**$130,772**	**$0**	**$130,772**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$98,115	$50,216		$50,216	$0		$0	$0		$0	$0		$0
6	Medicaid	$47,461	$23,016		$23,016	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$198	$915		$915	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$145,774**	**$74,148**	**$0**	**$74,148**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$92,300	$47,863		$47,863	$0		$0	$0		$0	$0		$0
10	Uninsured	$8,505	$4,315		$4,315	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$7,770	$3,923		$3,923	$0		$0	$0		$0	$0		$0
13	Other	$1,014	$523		$523	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$109,589**	**$56,624**	**$0**	**$56,624**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$255,363**	**$130,772**	**$0**	**$130,772**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$8,180	$4,961		**$4,961**			**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$247,183**	**$125,811**	**$0**	**$125,811**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$7,473	$4,950		**$4,950**			**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$733	$320		**$320**			**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$255,389**	**$131,081**	**$0**	**$131,081**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$88,793	$45,110		$45,110			$0	$0		$0	$0		$0
2	Fringe Benefits	$27,562	$14,267		$14,267			$0	$0		$0	$0		$0
3	Physicians Fees	$10,621	$5,693		$5,693			$0	$0		$0	$0		$0
4	Supplies and Drugs	$45,059	$21,814		$21,814		$0	$0	$0	$0	$0	$0	$0	$0
5	Depreciation and Amortization	$10,805	$5,737		$5,737			$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]	$0	$0		$0			$0	$0		$0	$0		$0
7	Interest Expense	$963	$119		$119			$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$3,802	$2,351		$2,351			$0	$0		$0	$0		$0
9	Lease Expense	$0	$0		$0			$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$22,512		$22,512		$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING EXPENSES	**$236,650**	**$117,603**	**$0**	**$117,603**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$18,739**	**$13,478**	**$0**	**$13,478**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE	**$2,522**	**$227**		**$227**			**$0**	**$0**		**$0**	**$0**		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$21,261**	**$13,705**	**$0**	**$13,705**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments	**$3,000**	$1,500		**$1,500**			**$0**			**$0**			**$0**

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	YTD March	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	7.3%	10.3%	0.0%	10.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	Hospital Non Operating Margin	1.0%	0.2%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	8.2%	10.4%	0.0%	10.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
D.	**FTEs**	1,384	1,387		1,387			0	0		0	0		0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	11,847	5,833		5,833			0			0			0
2	Outpatient Visits	238,522	125,267		125,267			0	0		0	0		0
	TOTAL VOLUME	250,369	131,100	0	131,100	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Trinity Health - New England, Inc. **NON-PROFIT**

Applicant:

Financial Worksheet (A)

LINE	Total Entity:	(1) FY 2016 YTD MARCH
	Description	
A.	**OPERATING REVENUE**	
1	Total Gross Patient Revenue	$ 1,294,926
2	Less: Allowances	861,377
3	Less: Charity Care	6,479
4	Less: Other Deductions	13,560
	Net Patient Service Revenue	**$ 413,510**
5	Medicare	160,517
6	Medicaid	55,304
7	CHAMPUS & TriCare	745
8	Other	-
	Total Government	**$216,566**
9	Commercial Insurers	197,920
10	Uninsured	7,417
11	Self Pay	-
12	Workers Compensation	5,168
13	Other	-
	Total Non-Government	**$ 210,505**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 427,071**
14	Less: Provision for Bad Debts	11,900
	Net Patient Service Revenue less provision for bad debts	**$ 401,610**
15	Other Operating Revenue	19,795
17	Net Assets Released from Restrictions	4,035
	TOTAL OPERATING REVENUE	**$425,440**
B.	**OPERATING EXPENSES**	
1	Salaries and Wages	$ 198,862
2	Fringe Benefits	48,421
3	Physicians Fees	14,703
4	Supplies and Drugs	71,607
5	Depreciation and Amortization	23,400
6	Provision for Bad Debts-Other[b]	-
7	Interest Expense	4,745
8	Malpractice Insurance Cost	6,193
9	Lease Expense	4,826
10	Other Operating Expenses	69,195
	TOTAL OPERATING EXPENSES	**$ 441,952**
	INCOME/(LOSS) FROM OPERATIONS	**$ (16,512)**
	NON-OPERATING REVENUE	(3,332)
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (19,844)**
	Principal Payments	**$3,326**

Trinity Health - New England, Inc. **NON-PROFIT**

Applicant:

Financial Worksheet (A)

LINE	Total Entity:	(1) FY 2016 YTD MARCH
	Description	
C.	PROFITABILITY SUMMARY	
1	Hospital Operating Margin	-3.9%
2	Hospital Non Operating Margin	-0.8%
3	Hospital Total Margin	-4.7%
D.	FTEs	4,762.8
E.	VOLUME STATISTICS[c]	
1	Inpatient Discharges	16,345
2	Outpatient Visits	568,914
	TOTAL VOLUME	585,259

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to related to the provision of direct services to patients. For additional information, information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT C

(YTD) financial measurements
Saint Mary's Health System, Saint Mary's Hospital and
TH-NE

Saint Mary's Health System

D. Additional Statistics (in thousands)

	Year to Date March 2016	Prior Year	Explanations
Income from Operations	$ 3,696	$ 1,819	YTD net patient revenue increased $7.6 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses increased $1.9 million mostly in labor costs, offset by reductions in purchased services and medical supplies.
Revenue Over/(Under) Expense	$ 4,199	$ 4,475	The increase from operations was offset by a decrease in non operating activity associated with investment returns and joint activity.
EBITDA	$ 9,930	$ 8,095	The increase is consistent with the increase in income from operations.
Patient Cash Collected	$ 148,477	$ 136,583	The increase is associated with the increase in net revenues, along with better cash collections in current year.
Cash and Cash Equivalents	$ 19,016	$ 20,017	Cash decreased as a result of the increase in Hospital Tax payments
Net Working Capital	$ 25,933	$ 36,932	In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April 2015. This increased net working capital for March 2015 by $15 million.
Unrestricted Assets	$ 36,778	$ 37,095	The decrease in unrestricted net assets is due to the increase in Hospital Tax and increase in the underfunded status of the pension plan.
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	

	Saint Mary's Health System	Month		Year to Date	
		March 2016	Prior Year	March 2016	Prior Year
A.	**Operating Performance**				
	Operating Margin	6.9%	3.2%	2.4%	1.2%
	Non-Operating Margin	-0.6%	1.2%	0.3%	1.8%
	Total Margin	6.4%	4.4%	2.7%	3.0%
	Bad Debt as % of Gross Revenue	1.3%	1.0%	1.3%	1.2%
B.	**Liquidity**				
	Current Ratio	2.12	2.25	2.12	2.25
	Days Cash on Hand	24	26	24	26
	Days in Net Accounts Receivable	41	42	41	42
	Average Payment Period	58	57	58	57
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.24	0.63	0.24	0.63
	Long-term Debt to Capitalization	0.20	0.39	0.20	0.39
	Unrestricted Cash to Debt	1.44	0.56	1.44	0.56
	Times Interest Earned Ratio	86.4	10.5	33.87	7.11
	Debt Service Coverage Ratio	11.9	7.4	6.62	5.40
	Equity Financing Ratio	3.85	4.01	3.85	4.01
D.	**Additional Statistics**				
	Income from Operations	$ 1,967,046	$ 801,240	$ 3,695,680	$ 1,819,011
	Revenue Over/(Under) Expense	$ 1,806,716	$ 1,106,507	$ 4,198,966	$ 4,474,726
	EBITDA	$ 2,985,409	$ 1,858,696	$ 9,930,131	$ 8,095,445
	Patient Cash Collected	$ 28,863,325	$ 24,057,295	$ 148,477,112	$ 136,583,386
	Cash and Cash Equivalents	$ 19,015,875	$ 20,017,346	$ 19,015,875	$ 20,017,346
	Net Working Capital	$ 25,933,351	$ 36,931,760	$ 25,933,351	$ 36,931,760
	Unrestricted Assets	$ 36,777,596	$ 37,095,324	$ 36,777,596	$ 37,095,324
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Saint Mary's Hospital

D. Additional Statistics (in thousands)

	Year to Date March 2016	Prior Year	Explanations
Income from Operations	$ 13,478	$ 9,375	YTD net patient revenue increased $5.2 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses decreased $2.5 million mostly in purchased services and medical supplies.
Revenue Over/(Under) Expense	$ 13,705	$ 12,443	The increase from operations was partially offset by a decrease in non operating activity associated with investment return and income from joint ventures.
EBITDA	$ 19,334	$ 15,368	The increase is consistent with the increase in income from operations.
Patient Cash Collected	$ 129,772	$ 120,161	The increase is associated with the increase in net revenues, along with better cash collections in current year.
Cash and Cash Equivalents	$ 17,614	$ 19,123	Cash decreased as a result of increase in Hospital Tax payments
Net Working Capital	$ 15,067	$ 28,338	In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April. This increased net working capital for March 2015 by $15 million.
Unrestricted Assets	$ 31,729	$ 32,236	The decrease in unrestricted net assets is due to the increase in Hospital Tax, increase in the underfunded status of the pension plan and funding to the Medical Group, offset by current year performance.
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	

	Saint Mary's Hospital	Month		Year to Date	
		March 2016	Prior Year	March 2016	Prior Year
A.	**Operating Performance**				
	Operating Margin	15.4%	7.3%	9.8%	7.1%
	Non-Operating Margin	-0.9%	2.9%	0.2%	2.3%
	Total Margin	14.5%	10.1%	10.0%	9.4%
	Bad Debt as % of Gross Revenue	1.3%	1.2%	1.2%	1.2%
B.	**Liquidity**				
	Current Ratio	1.81	2.06	1.81	2.06
	Days Cash on Hand	27	30	27	30
	Days in Net Accounts Receivable	40	41	40	41
	Average Payment Period	62	61	62	61
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.25	0.67	0.25	0.67
	Long-term Debt to Capitalization	0.20	0.40	0.20	0.40
	Unrestricted Cash to Debt	1.45	0.55	1.45	0.55
	Times Interest Earned Ratio	183.5	20.5	115.69	18.17
	Debt Service Coverage Ratio	19.3	10.5	12.89	10.25
	Equity Financing Ratio	3.87	4.04	3.87	4.04
D.	**Additional Statistics**				
	Income from Operations	$ 3,861,301	$ 1,608,253	$ 13,477,741	$ 9,374,825
	Revenue Over/(Under) Expense	$ 3,643,877	$ 2,240,864	$ 13,704,989	$ 12,442,790
	EBITDA	$ 4,830,843	$ 2,620,209	$ 19,334,355	$ 15,368,065
	Patient Cash Collected	$ 25,716,325	$ 21,143,295	$ 129,772,112	$ 120,161,386
	Cash and Cash Equivalents	$ 17,614,289	$ 19,123,132	$ 17,614,289	$ 19,123,132
	Net Working Capital	$ 15,066,620	$ 28,337,914	$ 15,066,620	$ 28,337,914
	Unrestricted Assets	$ 31,728,979	$ 32,235,922	$ 31,728,979	$ 32,235,922
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Trinity Health - New England

	March 16 YTD	March 15 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	(3.9%)	1.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	2.8%	7.6%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.0	2.1	current assets/current liabilites
Days Cash on Hand	53.5	76.5	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	34.5	38.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.3	55.0	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	149.8%	117.3%	total debt/total equity(net assets)
Long-term Debt to Capitalization	60.0%	54.0%	LTD/LTD+net assets
Unrestricted Cash to Debt	46.0	62.6	(cash and cash equiv+board restr. cash)/total debt (lt & st)*100
Times Interest Earned Ratio	(2.5)	1.9	EBIT/Interest expense
Debt Service Coverage Ratio	0.9 x	2.1 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	21.8%	23.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ (16,512)	$ 5,319	Net income(loss) from operations
Revenue Over/(Under) Expense	$ (19,844)	$ (11,271)	Net gain(loss)
EBITDA	$ 11,804	$ 30,785	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 100,142	$ 127,634	from cons bs
Net Working Capital	$ 106,041	$ 123,695	current assets-current liabilities
Unrestricted Assets	$ 93,165	$ 125,633	from cons bs

CON 15-32045 Financial Statistics

Trinity Health - New England

	March 16 YTD	March 15 YTD	Explanation
D. Additional Statistics			YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry
Income(Loss) from Operations	(16,512)	5,319	fees, merger due diligence, JMMC acquisition and purchase accouting including depreciation and SFMG's increased loss of ($2.7M).
Revenue Over/(Under) Expense	(19,844)	(11,271)	Variance in swap activity of $17.8M
EBITDA	11,804	30,785	YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry fees, merger due diligence and JMMC acquisition. SFMG's YTD loss increased ($2.7M).
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	100,142	127,634	Decrease in a/p ($7.3M); increase in due from affiliates $13.7M; funds expended for tail liablility $8.5M; JMMC purchase $2.3M; decrease in supplemental payments from the State; SWAP and debt termination expenses
Net Working Capital	106,041	123,695	Decrease in cash and cash equivalents ($26.7M); decrease in a/r patient ($4.6M), decrease in a/p ($7.3M)
Unrestricted Assets	93,165	125,633	YTD loss ($16.5M); increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Prefiled Testimony of James Richard O’Connell, Executive Vice President, East Group - Trinity Health

STATE OF CONNECITUCUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
DOCKET NUMBER: 15-32045-CON
May 9, 2016

Prefilled Testimony of James Richard O'Connell, Executive Vice President, East Group

Good afternoon,

I am James Richard O'Connell, Executive Vice President, East Group, Trinity Health and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today about Trinity Health and to seek the Office of Health Care Access' approval for the continued growth of Trinity Health-New England, Inc., our Regional Health Ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the Spirit of the Gospel as a compassionate and transforming healing presence within our communities. Our five core values guide our work:

- Reverence
- Commitment to those who are poor
- Justice
- Stewardship
- Integrity

As a mission-driven innovative healthcare organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become the national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health partner for life.

We are also dedicated to building a people centered health system that allows its organization to promote efficient and effective care management initiatives. These initiatives are helping us to shift our health care delivery approach from managing episodic events to providing a system of healthcare delivery focused on preserving the wellbeing and health of each person individually within our communities.

Since we last spoke to you in July 2015, Trinity Health has grown. Today, Trinity Health is a Catholic Health Care System that operates 90 acute care hospitals in 21 states as well as a wide range of home care, hospice, senior living and programs for the elderly. Our system employs about 95,000 full time employees including 3,900 employed physicians and we are affiliated with over 23,900 private practicing physicians as well.

Trinity Health supports the addition of Saint Mary's Hospital, Inc. and its related organizations to our Regional Health Ministry as an important step in the transition from episodic care delivery to a more holistic management approach of the health of individuals. This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those who will require our services. Building a strong Regional Health Ministry requires addition of proven health providers such as Saint Mary's.

Trinity Health is excited about this opportunity. It is an honor and privilege to be here in support of this important endeavor.

I am available to answer any questions you have of me.

Prefiled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

STATE OF CONNECITUCUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
DOCKET NUMBER: 15-32045-CON
May 9, 2016

Prefilled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

Good afternoon,

I am Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc. and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital, Inc. to our growing system.

Since we formed Trinity Health-New England, Inc. in October 2015, our system and Trinity Health nationally has continued to grow.

Adding Saint Mary's Hospital, Inc. and its related entities to Trinity Health-New England, Inc. will strengthen with Saint Mary's and our system by:

- Continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality and the provision of the right care at the right time in the most appropriate health care setting;

- Improving access to capital for strategic growth and clinical service enhancements;

- Supporting future capital investments of both organizations as well as securing Saint Mary's existing and future pension liabilities;

- Supporting system-wide efforts to recruit scarce health professionals and enhance the quality of the health services delivered to our patients through participation in evidence based initiatives and medical service innovation programs.

- Preserving Saint Mary's non-profit mission and Catholic identity, with its rich history of service to the Waterbury community, spanning nearly 110 years;

As was noted in the Certificate of Need application, Saint Mary's Hospital, Inc. began its search for a partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health-New England, Inc. and two members of the Saint Mary's Hospital, Inc. community will be appointed to the Trinity Health-New England, Inc. Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health-New England, Inc. and support our continued efforts to promote the health of all those who choose to use the health services provided by Trinity Health-New England, Inc.

I am available to answer any questions you have of me.

Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System

Good afternoon,

I am Robert Mazaika and I hereby adopt my testimony as submitted to the Office of Health Care Access.

The decision to become a part of Trinity Health – New England represents the culmination of a long and arduous process for Saint Mary's.

Our search for a strategic partner has been underway for more than 10 years. During this time we have met with many hospitals and health systems from around the country. As many of you know, we have made other proposals prior to this one. However, for a number of reasons those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as the chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is truly the best possible outcome for Saint Mary's, our staff, and most importantly—the communities we serve.

Our selection process was extremely rigorous. Because we were considering our options from a position of strength, we did not need to rush in to a decision, or compromise our principles. Our task force, and our board, carefully considered a number of options over a long period of time. Throughout this period, the healthcare industry has continued to evolve at a rapid pace. However, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and in turn created a series of "Guiding Principles for Affiliation" (attached herein), which served as our litmus test for any potential partner we were considering. Those principles included philosophical, financial, strategic, and people requirements.

- The **philosophical** principles focused on maintaining our community-based Mission, improving the delivery of care, and adhering to the Ethical and Religious Directives while maintain our Catholic identity.
- The **financial** principles focused on improving the net asset value of Saint Mary's, gaining access to capital, and satisfying our pension liability.
- The **strategic** principles included improving technology and the standard of care, and gaining access to regional and national resources.
- Finally, the **people** principles were focused on improving the recruitment and retention of talent, and creating opportunities to strengthen partnerships with the medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's; they represent a direct match for our heritage, our culture, our community, and our vision of the future. The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality healthcare in a spiritually enriched environment well in to the future.

Thank you.

Guiding Principles

SMHS will utilize the following guiding principles in evaluating potential partners:

Philosophical

- Fulfill our community-based Mission
- Improve the delivery of quality care
- Adhere to Ethical and Religious Directives and secure our Catholic Identity
- Maintain local governance and provide locally-based healthcare as part of a regional or national healthcare delivery system
- Enhance our current position as a charitable health system and hospital while being open to all possible structures to best serve the interest of Saint Mary's and our community

Strategic Position

- Acquire the necessary capital to sufficiently address our strategic capital needs
- Improve technology and the overall standard of care
- Provide regional and/or national scale, leverage and resources to address Health Reform requirements
- Improve future opportunity to regionalize and rationalize the Waterbury healthcare delivery system

Financial

- Improve the net asset value of Saint Mary's
- Improve access to and cost of capital
- Fully satisfy unfunded pension liability
- Improve opportunities to reduce costs by creating efficiencies and economies of scale
- Improve revenue cycle opportunities

People

- Improve our ability to meet our obligations to our staff
- Improve recruitment and retention of talent
- Create opportunities to strengthen partnerships with the Medical Staff

Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital

Good afternoon,

I am Dr. Steven Schneider and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today.

In my role as Chief Medical Officer I am focused on working effectively with both the medical staff and leadership and management of Saint Mary's.

I am very pleased to report that the proposal to become part of Trinity Health – New England has been met with widespread support from the medical staff.

As we all know, the healthcare delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care. While most physicians recognize the need for these changes, and are, in fact helping to drive and implement them, there is a sense of uncertainty that accompanies change of this magnitude.

Here in Connecticut, and specifically Waterbury, the changing landscape has left many physicians seeking a sense of stability. Becoming part of Trinity Health – New England provides exactly the sense of confidence and clear direction that many of our medical staff members desire.

Becoming part of Trinity Health – New England will strengthen and enhance a number of critical issues, including:

Physician recruiting and retention

Maintaining a vibrant, dynamic, and stable medical staff is essential to the health of our community. This applies to both primary care physicians and specialists. Yet recruiting physicians to our community has been a challenge. Becoming part of one of the largest health systems in the nation, with all of the attendant benefits, will make us far more attractive to physicians.

Investment in technology and facilities

New physicians are being trained using the most current clinical technologies, and they expect these to be available where they practice. This applies to everything from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

Changes in the care delivery system

The care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management. Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment

Through my many discussions with the physicians in our community it is clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health – New England.

Thank you.

Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital

Good afternoon,

I am Chad Wable and I hereby adopt my testimony as submitted to the Office of Health Care Access.

This hearing represents a significant milestone in the history of Saint Mary's and I am pleased to have the opportunity to speak with you today.

I moved to Connecticut and became a member of the Saint Mary's family in 2002. One of my first responsibilities was to work with our board to develop a new strategic plan for Saint Mary's. Our first strategic imperative, as far back as 2002, was to establish a partnership. So this is something that I have been working towards literally for as long as I have been at Saint Mary's.

During the past 13 years much has changed. Saint Mary's has become a far stronger and more financially stable organization. We have made incredible progress in clinical quality and safety. We have gown and added services. All around us, the healthcare landscape has changed at an unprecedented pace. We have witnessed the passing and implementation of the Affordable Care Act, the widespread adoption of electronic health records, the introduction of value-based purchasing and population health management. Here in Connecticut the landscape has changed significantly, with hospitals moving rapidly towards a system-based delivery model.

Similarly, Saint Mary's need to join a national or regional healthcare delivery system has evolved. What was once a financially driven decision is now a purely strategic issue.

Saint Mary's vision states that we "will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives."

Becoming part of Trinity Health will help us achieve this vision and accelerate the implementation of our strategic plan. Trinity's "People 2020" strategy is perfectly aligned with ours, and joining Trinity will help us with critical issues such as scale, resources, efficiency and expertise as we make the move towards population health. The specific benefits to Saint Mary's as a result of this proposal include:

- Having access to the resources of a large system which will allow SMHS to continue to provide quality health care services in the greater Waterbury area and be able to expand those services within its service area by making them more accessible to a greater number of people;
- Having the resources necessary to help develop more preventive and primary care services in the greater Waterbury area;
- Meeting the demands of the 2010 Patient Protection and Affordable Care Act which requires an emphasis on value rather than volume in terms of reimbursement for health care services;
- Creating efficiencies so that health resources are not wasted, which will also enable more patients to be served;
- Having readily available access to capital and financing for that capital at favorable interest rates; and
- Developing a plan to address Saint Mary's pension plan obligation.

Although the details of our proposal are contained in our application, there are a few highlights that bear mentioning. This proposal is an organizational change that will allow Saint Mary's to become part of Trinity Health – New England. There is no change in clinical services requested, nor is there any change of location involved with any of the clinical services now being offered by SMHS as a direct result of this proposal. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

Additionally, Trinity Health has agreed to ensure the expenditure of One Hundred Million Dollars for capital expenditures at Saint Mary's over the first five years following the effective date of the Transaction. This committed capital will be available to support the capital needs of Saint Mary's,

including strategic growth and infrastructure development for it's integrated delivery system including both facilities and physician network development.

As a result of this Transfer Agreement, the Parties intend to:

- improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area, including SMHS's Waterbury service area;
- enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to safety and satisfaction;
- reduce the costs of healthcare in the NE-RHM Service Area, including SMHS's Waterbury service area;
- Support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

Finally, Trinity's heritage, culture, and values are a perfect match for Saint Mary's, and help make this a time of great excitement and optimism. The opportunity before us to become a member of a not-for-profit, Catholic health care organization is an extremely straight-forward transaction; however it is very significant. This transaction will cement our over100 year history into the business and healthcare fabric of Waterbury for another 100 years. The heritage and work of our founders and the Sisters of St. Joseph's will be protected. We are privileged to have the opportunity to join Trinity Health, an impressive, national, people centered organization with great talent, resources and values.

Our CON application provides much more information on this proposal.

I look forward to answering any questions you may have.

Thank you.

Closing Remarks of James Richard O’Connell, Executive Vice President, East Group - Trinity Health

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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May 9, 2016

Closing Remarks of James Richard O'Connell, Executive Vice President, East Group

Trinity Health's vision of becoming a national leader in improving the health of our communities and the most trusted health care partner for Life for each person we serve will be strengthened by the addition of Saint Mary's Hospital and Health System to our Regional Health Ministry, Trinity Health – New England, Inc.

We recognize the many challenges faced by Connecticut today, but know that forging local partnerships with committed, high quality, non- profit health care providers is the key to ensuring a truly integrated health system that promote better healthcare for all.

We also believe that preserving Catholic healthcare institutions is also critically important to ensuring our unique approach will provide the neediest people in each local community the access to care they deserve.

Thank you for your continued support of Trinity Health's collective efforts to create a better tomorrow for all we serve.

Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

Since 2015 when Trinity Health - New England Inc. was formed our goal of offering people centered health care closer to home has made significant strides in a very short time. Our efforts toward improving population health, enhancing the patient care experience and controlling cost while maintaining a positive margin will be strengthened with the addition of Saint Mary's Hospital and Health System to our organization.

Equally important the 100 plus years of Saint Mary's exemplary service to the Waterbury community is both preserved and strengthened.

If approved, together the organizations that would constitute Trinity Health – New England, Inc. represent over 300 years of continuous, high quality, non –profit health care service delivery to multiple communities across the state of Connecticut.

Our institutions are open 24 hours a day, seven days a week to all in need. Trinity Health – New England Inc. is truly a part of the fabric of Connecticut's health system. Please support its efforts to continue to serve the citizens of Connecticut for another hundred years.

Thank you very much.

Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital

Saint Mary's is integral to the fabric of Greater Waterbury. This proposal will position us to maintain our identity as a faith-based, not-for-profit hospital and continue our great tradition of service to the community for many years to come.

Becoming part of a regional or national system has been at the core of our strategic plan for many years. Trinity Health provides all of the resources and expertise needed to accelerate and implement our strategic plan, while also honoring our faith based heritage and deep community roots. Our collective commitment to people-centered care will be the foundation of all that we do.

The creation and growth of a strong, progressive regional health ministry serving New England positions Saint Mary's to effectively deal with the shift to population health management and other changes in the healthcare delivery system locally and regionally. Our ability to invest in our future will help us to attract and retain the most talented physician and caregivers, and provide our patients and families with the most appropriate standard of care.

Our vision of the future is bright. On behalf of the 2,000 members of the Saint Mary's family we look forward to having our proposal approved so we can begin the exciting work of making our vision a reality.

Thank you for the opportunity to present our proposal.

Greer, Leslie

From: Mercier, Carlene M. <CMercier@brownrudnick.com>
Sent: Tuesday, May 10, 2016 1:45 PM
To: User, OHCA
Cc: chartley@stfranciscare.org; Anthony, Robert J.; Teitelbaum, Claudia S.; helmecki@ct.gov
Subject: Docket No. 15-32045-CON / Appearance
Attachments: Saint Mary_s _ Trinity - Appearance for R. Anthony.PDF

Hello,

Attached for filing in Docket No. 15-32045 (Saint Mary's / Trinity - Transfer of Ownership) is an Appearance for Bob Anthony on behalf of Saint Mary's. Please let me know if you need anything further.

Best Regards,
Carlene

BROWNRUDNICK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE	:	**Docket No. 15-32045-CON**
	:	
CERTIFICATE OF NEED APPLICATION FOR SAINT MARY'S HEALTH SYSTEM, INC. AND SAINT MARY'S HOSPITAL, INC.'S TRANSFER OF OWNERSHIP AND CONTROL TO TRINITY HEALTH – NEW ENGLAND, INC., FORMERLY KNOWN AS SAINT FRANCIS CARE, INC.	:	**MAY 10, 2016**

APPEARANCE

An appearance on behalf of Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. in the above-mentioned docket is hereby submitted.

Robert J. Anthony, Esq.
Brown Rudnick LLP
CityPlace 1
185 Asylum Street
Hartford, CT 06103
Tel. 860-509-6517
Email: ranthony@brownrudnick.com

Respectfully Submitted,

Robert J. Anthony/cm

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

SAINT MARY'S HEALTH SYSTEM, INC.
TRINITY HEALTH, INC.

TRANSFER OF OWNERSHIP OF SAINT MARY'S HOSPITAL SYSTEM TO TRINITY HEALTH, INC.

DOCKET NO. 15-32045-CON

MAY 9, 2016

3:00 P.M.

COURTYARD BY MARRIOTT WATERBURY
63 GRAND STREET
WATERBURY, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Saint Mary's Health System, Inc., Trinity Health, Inc., transfer of ownership of Saint Mary's Hospital System to Trinity Health, Inc., held at the Courtyard by Marriott Waterbury, 63 Grand Street, Waterbury, Connecticut, on May 9, 2016 at 3:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Okay, folks, we're going to get started here. Okay, we're on the record. Good afternoon, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 15-32045-CON, is being held on May 9, 2016 to consider Saint Mary's Health System, Inc. and Trinity Health, Inc.'s application for the transfer of ownership of Saint Mary's Hospital system to Trinity Health, Inc.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General

Statutes.

My name is Kevin Hansted, and I have been designated to serve as the Hearing Officer for this matter.

The staff members assigned to this case are Kaila Riggott, Jessica Schaeffer-Helmecki, David Fernandes and Ronald Ciesones. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Saint Mary's Health System, Inc. and Trinity Health Corporation have been designated as parties in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this matter.

All documents have been identified in the Table of the Record for reference purposes.

MS. JESSICA SCHAEFFER-HELMECKI: My name is Jessica Schaeffer-Helmecki, and, on behalf of OHCA, I'd like to request that Exhibits A through L be entered into the record.

HEARING OFFICER HANSTED: Thank you. And there is one correction I'd like to make, just one bit of housekeeping.

On the order regarding administrative notice, dated April 27, 2016, which is Exhibit K on the Table of the Record, in that order, letter B, it says Exhibit D, completeness responses, page 1974. The page number should be 1947.

Does the Applicant have any objection to any of the exhibits? No objection? If you could just state that on the record?

MR. CHRIS HARTLEY: Chris Hartley, St. Francis. For the record, no.

HEARING OFFICER HANSTED: Okay, thank you. And for this afternoon's hearing, we will first hear from the Applicant for an overview of the project, and then, if there are any individuals signed up to give public comment, we will hear from them.

We, of course, will take elected officials first, and then read the names off of the public comment sign-up sheet in the order that they have signed up.

Then, after the public comment, we will have some questions from OHCA, and then, if there are any other public commenters, we will take them at that time.

And, at this point, would all the individuals, who are going to or think they may testify, please stand, raise your right hand and be sworn in by the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay, thank you, all. And just for clarity on the record, each of you, who have just taken the oath, would you please identify yourself in one of the microphones closest to you, including the folks sitting in the back rows? Whoever wants to start can do so.

MR. RALPH BECKER: Ralph Becker with Saint Mary's.

MR. DAVID BITTNER: David Bittner. I'm the Chief Financial Officer for Trinity Health New England.

MS. JENNIFER SCHNEIDER: Jennifer Schneider, Vice President of Finance, St. Francis Hospital and Medical Center.

MR. HARTLEY: Chris Hartley, St. Francis.

MR. CHRISTOPHER DADLEZ: Christopher Dadlez, President and CEO, Trinity Health New England.

MR. JAMES RICHARD O'CONNELL: James

Richard O'Connell, Trinity Health.

MR. CHAD WABLE: Chad Wable, President and CEO, Saint Mary's Hospital and Saint Mary's Health System.

MR. ROBERT MAZAIKA: Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System.

DR. STEVEN SCHNEIDER: Dr. Steve Schneider, Chief Medical Officer, Saint Mary's Hospital.

MR. JOE CONNOLLY: Joe Connolly, Vice President of Administration, Saint Mary's Hospital.

MR. BOB ANTHONY: Bob Anthony, attorney for Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay, thank you. And I know we have some folks in the second row.

DR. ADAM SILVERMAN: Adam Silverman, Vice President, Ambulatory Strategy, Trinity Health New England.

DR. MARCUS McKINNEY: Marcus McKinney, Vice President of Community Health, Trinity Health New England.

MR. MICHAEL TALBERT: Michael Talbert, attorney for Trinity Health New England.

MS. LIZ RODAREO: Liz Rodareo, St. Francis Hospital.

MR. JIM HARRIS: Jim Harris, Trinity Health New England.

MR. JURCZYK: Kyle Jurczyk, Saint Mary's Hospital.

MR. CHRIS HAYES: Chris Hayes, Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay. I think that's everyone. And for the two attorneys that are present here today, I know we have one for the hospital and one for Trinity, do you intend on filing appearances in this matter?

MR. ANTHONY: Yes. This is Bob Anthony. Yes, we do.

HEARING OFFICER HANSTED: Okay. All right. Would you just file those this week, just so I have them on the record? Thank you.

Okay, at this point, the Applicants may proceed with their opening presentation.

MR. O'CONNELL: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. O'CONNELL: I'm James Richard O'Connell, Executive Vice President of the East Group for Trinity Health, and I hereby adopt my testimony, as submitted for the Office of Health Care Access.

HEARING OFFICER HANSTED: Thank you.

MR. O'CONNELL: Thank you for the opportunity to speak to you today about Trinity Health and to seek the Office of Health Care Access approval for the continued growth of Trinity Health New England, Inc., our regional health ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the spirit of the gospel as a compassionate and transforming, healing presence within our communities.

Our five core values guide our work; reverence, commitment to those who are poor, justice, stewardship, integrity.

As a mission-driven innovative health care organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become a national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health care partner for

life.

We are also dedicated to building a people-centered health care system that allows its organization to promote efficient and effective care management initiatives.

These initiatives are helping us to shift our health care delivery approach for managing episodic events to providing a system of health care delivery focused on preserving the well-being and health of each person individually within our communities.

Since we last spoke to you in July of 2015, Trinity Health has grown. Today, Trinity Health is a Catholic health care system that operates 90 acute care hospitals in 21 states, as well as a wide range of home care, hospice, senior living and programs for the elderly.

Our system employs about 95,000 full-time employees, including 3,900 employed physicians, and we are affiliated with over 23,900 private practicing physicians, as well.

Trinity Health supports the addition of St. Mary's Hospital, Inc. and its related organizations to our regional health ministry as an important step in the transition from episodic care delivery to the more

holistic management approach of the health care of individuals.

This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those, who require our services.

Building a strong regional health ministry requires addition of proven health providers, such as Saint Mary's. Trinity Health is excited about this opportunity. It is an honor and a privilege to be here in support of this important endeavor.

I'm available to answer any questions you may have of me.

HEARING OFFICER HANSTED: Thank you.

MR. DADLEZ: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. DADLEZ: I'm Christopher M. Dadlez, President and CEO of Trinity Health New England, and I hereby adopt my testimony, as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital to our growing system.

Since we formed Trinity Health New England

in October of 2015, our system and Trinity Health nationally has continued to grow. Adding Saint Mary's Hospital and its related entities to Trinity Health New England will strengthen Saint Mary's and our system by continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality, and the provision of the right care at the right time in the most appropriate health care setting.

Improving access to capital for strategic growth and clinical service enhancements, supporting future capital investments at both organizations, as well as securing Saint Mary's existing and future pension liabilities, supporting system-wide efforts to recruit scarce health care professionals and enhance the quality of the health services delivered to our patients through participation in evidence-based initiatives and medical service innovation programs.

Also, preserving Saint Mary's not-for-profit mission and Catholic identity with its rich history of service to the Waterbury community spanning nearly 110 years.

As was noted in the Certificate of Need application, Saint Mary's Hospital began its search for a

partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health New England, and two members of the Saint Mary's Hospital community will be appointed to the Trinity Health New England Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health New England and support our continued efforts to promote the health of all those, who choose to use the health services provided by Trinity Health New England, Inc.

I'm available to answer any questions you may have. Thank you so much.

HEARING OFFICER HANSTED: Thank you.

MR. WABLE: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. WABLE: I'm Chad Wable, President and CEO of Saint Mary's Hospital and Saint Mary's Health System, and I hereby adopt my pre-filed testimony.

First of all, I'd like to thank all of you for bringing us together today for this very important hearing. I want to thank all of you and the involved agencies for the diligence and work in reviewing our application.

Since 2002, Saint Mary's saw the value and

importance in forming a broader, larger partnership with a national or regional system. Over the past decade, we've been truly blessed to have been able to grow stronger and more stable and to affirm ourselves as a highly-respected and trusted hospital and health care company.

We have added services and programs. We have added numerous jobs. We have added several physicians and clinicians to our medical group and medical staff to better serve the Greater Waterbury area.

Everything we do at Saint Mary's is grounded in our Catholic values and mission and focused by our vision, a vision perfectly aligned with Trinity's vision and their People 2020 strategy.

Joining Trinity is almost surreal to me, considering what we have been able to accomplish independently and our many attempts at forming a larger, broader strategic partnership through the years.

This partnership with Trinity Health is so perfect for us and so perfect for our people in our community. The scale, the resources, the efficiency and expertise will certainly move us towards our collective vision of value in population health.

The benefits to Saint Mary's of joining

Trinity Health are endless. Our proposal was so straightforward, Catholic-to-Catholic, not-for-profit and not-for-profit and so on.

And through our member substitution, there's nearly no organizational changes, no service changes, and no exchange of money.

What does change is we, in our community, get a great deal of stability, security, certainty and confidence in Saint Mary's, confidence in health care for Waterbury, and confidence for the health of our community as we look so positively to the future.

This is a time of great enthusiasm, a time of great excitement, and a time of great optimism for the entire Saint Mary's family and for the Greater Waterbury community.

What is most perfect is this transaction will cement our over 100-year history into the business and health care fabric of Waterbury for another 100 years.

The heritage and work of our founders and sisters of St. Joseph's will be protected, and it will live on with great hope and promise.

We are privileged to have the opportunity to join Trinity Health, an impressive, national, people-

centered organization, with great talent, resources and values.

I look forward to answering any questions that you may have.

HEARING OFFICER HANSTED: Thank you.

MR. MAZAIKA: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. MAZAIKA: I'm Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System. I hereby adopt my testimony, as submitted to the Office of Health Care Access.

The decision to become part of Trinity Health New England represents the culmination of a long and arduous process for Saint Mary's Health System.

Our search for a strategic partner has been underway for more than 10 years. During this time, we have met with many hospitals and health systems from around the country.

As many of you know, we have made other proposals prior to this one, however, for a number of reasons, those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as Chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is

truly the best possible outcome for Saint Mary's, our staff, and, most importantly, the communities we serve.

Our selection process was extremely rigorous, because we were considering our options from a position of strength. We did not need to rush into a decision or compromise our principles.

Our Task Force and our Board carefully considered a number of options over a long period of time. Throughout this period, the health care industry has continued to evolve at a rapid pace, however, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and, in turn, created a series of guiding principles for affiliation, which served as our litmus test for any potential partner we were considering.

Those principles included philosophical, financial, strategic and people requirements. The philosophical principles focused on maintaining our community-based mission, improving the delivery of care, and adhering to the ethical and religious directives, while maintaining our Catholic identity.

The financial principles focused on improving the net asset value of Saint Mary's, gaining

access to capital, and satisfying our pension liability. The strategic principles included improving technology and the standard of care and gaining access to regional and national resources.

Finally, the people principles were focused on improving the recruitment and retention of talent and creating opportunities to strengthen partnerships with our medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's. They represent a direct match for our heritage, our culture, our community and our vision for the future.

The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians, who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality health care in a

spiritually-enriched environment well into the future.

Thank you very much for your attention.

HEARING OFFICER HANSTED: Thank you.

DR. SCHNEIDER: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

DR. SCHNEIDER: I am Dr. Steve Schneider, Chief Medical Officer at Saint Mary's Hospital, and I hereby adopt my testimony, as submitted to the Office of Health Care Access. Thank you very much for the opportunity to speak with you today.

In my role at the hospital as Chief Medical Officer, I am focused primarily on working effectively with both the medical staff and the leadership and management of Saint Mary's Hospital.

I am very pleased to report that the proposal to become part of Trinity Health New England has been met with widespread support from our medical staff.

As we all know, the health care delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care.

While most physicians recognize the need for these changes and are, in fact, helping to drive and implement them, there is a sense of uncertainty that

accompanies change of this magnitude.

Here in Connecticut and, specifically, in Waterbury, the changing landscape has left many physicians seeking a sense of stability.

Becoming part of Trinity Health New England provides exactly that sense of confidence and clear direction that many of our medical staff members and physicians in the community desire.

Becoming part of Trinity Health New England will strengthen and enhance a number of critical issues, including first physician recruiting and retention. Maintaining a vibrant dynamic and stable medical staff is essential to the health and well-being of the community.

This applies to both primary care physicians and specialists, yet recruiting physicians to our community has been a challenge.

Becoming one of the largest health systems in the nation, with all of the benefits, will make us far more attractive to physicians.

Next, investment and technology and facilities. New physicians are being trained using the most current clinical technologies, and they expect these technologies to be available where they practice.

This applies to everything, from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

Lastly, changes in the health care delivery system, itself. The health care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management.

Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment.

Through my many discussions with physicians in our community, it's clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action that this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health New England. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. HARTLEY: That concludes our initial presentation.

HEARING OFFICER HANSTED: Okay, thank you.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: We will go to OHCA's questions. Ms. Riggott, do you want to begin?

MS. KAILA RIGGOTT: Sure. Kaila Riggott, OHCA staff. I'm not sure. There may be different individuals, who will answer these questions, so I'll just pose them generally.

Based on your application, pre-filed testimony, etcetera, OHCA has certain areas of interest we'd like to have a brief discussion about and also want to understand if you have any concerns or challenges regarding them. These would include CHNAs, community benefit, Board makeup, etcetera.

You've mentioned in your response to OHCA's interrogatories that the CHNA is scheduled to be completed in June and the implementation plan mid-November.

In your application, you stated that the New England Regional Health Ministry and Saint Mary's are currently addressing the community needs within the Saint

Mary's community and will continue to do so if the CON is approved.

Specifically, how will this proposal affect the implementation plan being developed to address priority health needs identified in the CHNA, how does Trinity and the Regional Health Ministry support the CHNA, and how will they be participating in the process?

MR. HARTLEY: Chris Hartley of St. Francis. I want to ask Joe Connolly to speak to where things stand on the Waterbury Community Health Needs Assessment, and then Dr. Marcus McKinney will talk about how we're integrating that with what we're doing in the rest of Trinity Health New England that ties to the Community Health Needs Assessment and Strategic Implementation Plan you raised as a question. Joe, you want to start?

MR. CONNOLLY: Sure. I'm Joe Connolly from Saint Mary's, and, as Bill Quinn said, we have a very robust partnership here in Waterbury that Saint Mary's is a founding partner of, both participation not only from health care providers, but, in addition to that, some of the other funders in the city, both of our large philanthropies are involved, and it's been an ongoing process.

We've used research that was conducted in 2013 when we did our initial needs assessment. We've re-upped and had another round of research that was completed earlier this year.

As opposed to changing anything, I think it's a refocusing, so, for instance, where we were talking about some of our chronic health conditions last time, this year, for instance, we're going to be looking at a more narrow focus on asthma, which is consistent with what's going on at the Connecticut Hospital Association, consistent with other programs here in the state, so I think that it's an evolution and a refocusing and a continuing of what has been set forth, and there's ongoing communication from all the partners to make sure that that work continues.

And, as Chris just alluded to, Marcus McKinney could add to that, but we certainly see, from the Saint Mary's perspective, that the experience and commitment that St. Francis is bringing to that and Trinity Health is going to help accelerate that and provide some perspective that we might not already have here in our community.

DR. McKINNEY: Hi. Marcus McKinney, Vice President for Community Health for Trinity Health New

England.

So several things surface to the top to try to address how we support for Trinity Health New England, the Waterbury area and Saint Mary's.

First, we would refer to the hub of community health and health equity work at our Trinity Health New England system is the Curtis D. Robinson Center for Health Equity.

That will be an approach that will allow for team extension into Waterbury, as it has in Springfield and in Hartford and for Johnson Hospital, Johnson Memorial Hospital.

That is a team of eight individuals, multi-cultural, multi-lingual, that really amends Vice President Connolly's comments, and, also, I would refer back to the earlier comments of the Director of Health in Waterbury, because the community health strategy that Trinity referenced to be a speaker of at ACHI meeting, the Community Health Improvement meeting in March, really is community health and well-being.

So what we would be glad to do for you is really highlight that the community health and well-being is the strategy, and well-being touches all those social determinant issues, so the strategy baits into the

priories of obesity, tobacco, to be at the highest level of concern for strategies that's already in the Greater Waterbury strategy, the partnership that was mentioned by the Director of Health, but really would be able to amend it by the resources and insight from a regional approach, which includes Hartford.

So our Center for Health Equity and the fact that we're looking at well-being and where are we getting that from, we're getting the information from the existing health needs assessment that's taking place by DataHaven, and DataHaven you may remember, some of you, is a first of its kind health and well-being assessment in this country, and it's for all of our hospitals that are implicated here in Connecticut.

So we have the first set of questions from the community that touches on social determinate issues. That will help inform implementation plans to support the Waterbury region and Saint Mary's.

MR. DADLEZ: In addition, we also had the national initiatives at the corporate headquarters of Trinity and Detroit, where we have a Senior Vice President for Community Outreach and his whole team that is providing resources for the regional ministries, in addition, so this is a comprehensive commitment that

Trinity Health has made significantly to the communities that it serves.

One of its primary focus is community outreach and community health and well-being and the people that we serve, so there are dramatic resources throughout the whole organization that are available.

MS. RIGGOTT: And just to follow-up on that, the resources would consist of?

MR. DADLEZ: First of all, resources that consist of the talent and the content experts that we have, both on a national level and a regional level.

I mean I think that first the priority is the mindfulness of that and the focus that we have and those people that have been trained and have been doing this work for years and years.

There's also a financial commitment that Trinity basically has set aside a significant portion of its budget this past year to really focus on things, like obesity and tobacco use and those kind of things in all the different regions comprehensively across the state.

They setup specific guides and parameters and expectations for each of the health ministries to meet all across the nation, so this is kind of -- the point is it's hardwired into what we do, and it's a very

significant commitment.

MS. RIGGOTT: Thank you. In the application, it was stated that, for Trinity Health, success will be measured against the triple aim objectives, its ability to actually deliver on all three dimensions of better health, better care and reduced costs.

Does Trinity have any outcome data on which to measure these successes?

MR. O'CONNELL: This is James O'Connell from Trinity Health.

We have a lot of outcome measures and a lot of strategic aims. What we've done is positioned ourselves to where we want to be in the top quartile by 2020 in all of our ministries across the organization, and those are all measured differently, so lowest cost provider, highest quality and highest satisfaction.

We use national data to benchmark against, so it's the HCAHPS for the patient care experience. Quality, we have a very sophisticated quality score card that measures across the full continuum of services that we have, and we compute that into GPA, and we have all of our facilities measured on that every month along the way, so we know, prior to something happening, that we're

going in the wrong direction, or we're going in the right direction, so we use those measures for our success.

The truth will be, you know, for those payers at the end of the day, who want to contract with us to provide their care, because they're going to look for the highest quality, lowest cost facilities available, and we hope to have 75 percent of all of our contractual arrangements in an alternative payment form by 2020. That's our other measure.

MS. RIGGOTT: Thank you. Next question. OHCA is interested in encouraging community building activities that are aimed at addressing the social and economic determinants of health and examining the outcomes and cost effectiveness of improvements that result from community building activities.

Saint Mary's most recently submitted 990s. I believe it shows that physical improvements and workforce development appeared under the community building activities.

With respect to community benefit and community building, are there plans to align with the CDC's 618 initiatives interventions and/or Healthy People 2020?

MR. CONNOLLY: The CDC program is one that

we participated in as a community this year, and the asset not only is Saint Mary's, but throughout the rest of the community, as well, so I think that it was -- we spent six months studying that. We had representatives actually participate in the meeting where a lot of those initiatives were laid out, and the recommendations that we are making not only to ourselves as an organization, but community-wide, are completely consistent with that, so I would say yes.

MS. RIGGOTT: Okay. In your application, also, you state that Saint Mary's is committed to supporting its community and is projecting a three percent increase annually as part of New England Regional Health Ministry, and Saint Mary's will be able to collaborate on planning activities on a regional level, leveraging the expertise and resources of the Regional Health Ministry.

Can you please confirm your plans to increase the level of community benefit provided as a result of this acquisition?

MR. HARTLEY: Can you tell us what page you're referring to?

MS. RIGGOTT: I believe it's page 85. I believe it mentions projecting a three percent increase

per year. I may not have the right page. It's at the response to the first part of --

MR. HARTLEY: Chris Hartley. I believe you're talking about the response above on Exhibit S6? Is that what you're talking about?

MS. RIGGOTT: Um-hum. Yeah. It refers to Exhibit 17, question O.

MR. HARTLEY: Chris Hartley, St. Francis. We're looking at page A46. This is talking about the increase in community benefits that's measured each year through our community benefits report and looks at how much increase in delivery of community benefits we've had.

If you look at our latest community benefit report for St. Francis, the actual $78 million we gave in 2014 in community benefits is measured by that program. It actually went to 104 million in 2015, primarily driven by the shortfalls in Medicaid payments for care and other government payments.

So one of the biggest contributors for the growth in that area is the continued reduction in provision of payments for Medicaid and Medicare patients that use services, and that commitment to continue to grow is basically exceeding three percent at this point

in time, and we'll continue that commitment to the patients that need our care, and, unfortunately, that care payment has been continually reduced as part of the program. That's what that's referred to.

MS. RIGGOTT: Thank you. And then, with respect to charity care, can you confirm for the record that you are committed to either maintaining or increasing the level of charity care as a result of the acquisition, and there would be no concerns in notifying OHCA if there were any changes in that level?

MR. HARTLEY: We provided information in the application that says that our charity care policies will continue. There should be no change.

What we did in the earlier applications, we actually met the most stringent standards of Trinity Health Care for our previous parts of the system. We'll continue to do it with Saint Mary's as part of the program.

MS. RIGGOTT: Thank you. My next question is regarding evidence-based initiatives. Mr. Dadlez, you mentioned in your pre-filed testimony the acquisition will enhance the quality of health services delivered to patients through participation in evidence-based initiatives and medical service innovation.

Can you elaborate a bit and discuss your top proprieties with respect to these initiatives and innovation?

MR. DADLEZ: Let me think what the best answer to that is. Pulling together an organization, such as we are, offers a tremendous opportunity to really develop and foster and grow really top quality health programs.

Because we have the size and the intellectual capital of our clinical enterprise that is in a regional basis and together with the intellectual capital and all the research and development and resources of Trinity Health, that's a national organization that's looking at all these quality initiatives, we're going to be working together in bringing people together on many, many clinical initiatives.

It's not just -- it's hard to say, you know, just one. There are many clinical initiatives, where we will get synergies, and we will be able to become more efficient and effective and raise the bar on creating standards of care.

So what we're going to be doing is are standardizing and taking variation out of the system and

creating a greater opportunity to really provide the utmost care, so, for example, we have three bariatric programs currently in our region.

They're all independent. They all have their own individual standards of care, and what we're doing are pulling together leadership in those, as an example, in that clinical entity, and all of those individuals will be looking at and fostering and developing what's the best clinical programming as a system and raising the bar and saying this is a better way of taking care of those bariatric patients.

For example, we may not need three centers. Maybe it will be better to consolidate some of those operations and just do them in Waterbury or whatever we believe, but the opportunity is to bring all those people together and really use their expertise and clinically develop those types of initiatives.

We can have other people to even address that. I don't know if you would want to, or maybe Dr. Silverman, or others may want to comment on that.

MR. HARTLEY: Chris Hartley. If you refer to page 1027 and 1028 of the application ?? there we list some of the ways in which working with Trinity will bring additional quality initiatives ??

One of the things Trinity has is the universal -- there's a clinical access system that we use as part of our organization that basically sets standards for physicians' care across all of our system, uses evidence-based practices to deliver that care.

We see that employed also through our clinical service centers of excellence that will manage to map those centers of excellence with those at Saint Mary's using standard protocols across all of our system to ensure common clinical protocols and common treatment as part of the program.

We also basically are going to be using similar clinical protocols for all our physician groups throughout the system, which ensures common treatment for patients, as well as the same health information system across all of our system, again, being able to move patients within our system and keep the same medical records and keep the information together for those patients. It's part of our initiative to raise the quality of care there.

Actually, this is a question that should be answered by a clinician. I'm not a clinician, so, Adam, Dr. Silverman, you may want to comment on this.

DR. SILVERMAN: Hi. Adam Silverman, Vice

President for Ambulatory Strategy at Trinity Health New England.

I think Mr. Hartley started to get into where I believe the real value of bringing Trinity Health to Connecticut and Western Massachusetts is really benefitting the patients through the clinicians on the ground, and part of that is this unified clinical organization that Mr. Hartley was describing, where, regardless of what program we're talking about, what we want to look for across our system and the real value of the system is to find what I'll call best in breed, so who is doing best in whatever program we're talking about.

It could be an open heart program. It could be an obesity program. It could be care of the elderly. How do we keep the older adult population living independently longer?

Up until now, it's been what locally we have in our own particular organizations that really have driven sort of either the evidence-based or, when the evidence is lacking, the best practice.

Now we have partners across the country in 22 states, who have struggled with the same thing. Some are a bit ahead of us, some are a bit behind us, and it

saves us from having to recreate the wheel, so we can bring that evidence-based or that best practice to bear more rapidly by being connected to this unified clinical organization for our physicians.

Rather than go program-by-program, it's who are the high-risk patients? Who are the ones that we need to identify today, who are going to be our patients tomorrow? How do we keep them healthier? How do we keep them out of the hospital? How do we keep them out of the emergency room? How do we reduce the cost and the time that they spend in the health care system, and how do we improve their overall well-being moving forward?

MS. RIGGOTT: Thank you.

MR. HARTLEY: Chris Hartley. Just one other thing to point out. This is multi-dimensional. Basically, we work with Trinity Health on the state and local basis on legislative changes that are necessary to encourage program development.

On Tobacco 21, for example, what we think is a best care scenario. Basically, we help to work passing an increase in the smoking age from 18 to 21. We didn't succeed this year, but that's part of Trinity's ongoing initiatives across the country, to move the tobacco age up, because there's evidence base that if you

move the age up for people to begin smoking, fewer people actually start.

We also work with obesity programs nationally, and we look at them locally to try to promote those programs, as well, as part of our evidence-based practice at reducing obesity, particularly in the poor populations, as a way to manage a variety of health issues, including diabetes, amongst others, so we're part of that.

We're part of a national what's called a Tiger Teams Initiative to expand access to behavioral health services nationally, on a national level and locally, to make sure that we have mental health parity for all patients and families in this community, so those are all initiatives that we work on, as well, as we work with Trinity to try to move those issues forward nationally and statewide.

MS. RIGGOTT: Thank you. My next question is for Mr. Wable. You mentioned in your pre-filed testimony via the transfer agreement that parties intend to reduce the cost of health care in the New England Regional Health Ministry service area and St. Mary's Waterbury service area.

Can you elaborate on how this is intended

to be accomplished?

MR. WABLE: Sure. I think there's probably multiple ways that this will be attended to. I think, first, on the local level, we're always looking at ways to be more efficient, through better productivity management, better management across the entire health system. That's the first and foremost, is what can we do locally?

Regionally, we're going to be able to then work together to figure out where there might be a certain amount of synergies where we can work better together.

An example of that is through supply chain alone, both on the regional and national level. Hopefully, we'll be able to buy products and services at a lower cost as a result of multiple parties working together to accomplish that. That's another example.

The third way will be best practices across all the different entities, so each one of us may take care of a surgical patient or a medical patient a little different than one another, being able to have forums, where physicians and clinicians and administrators can come together and learn what those best practices might be and roll those out within a

region or use national best practices to roll out where there have been either cost saving, evidence of cost savings nationally, or regionally, or otherwise, where we can continue to reduce cost, and I think, through all of those prongs, we will be able to reduce costs over time.

MS. RIGGOTT: Okay, thank you. My next question is regarding the makeup of the Board. In the application, it was stated that the New England Regional Health Ministry Board of Directors will appoint two members from the Saint Mary's community to the Board.

It's important to OHCA to have true community representation on the Board, and I'm wondering if there are alternatives to having community members selected by the Board.

We are most interested in someone, who can bring the community's concerns to the hospital and likewise bring hospital information to the community.

MR. DADLEZ: Well I'm sure you know that the organization is a community not-for-profit organization, and all the Board members that serve are volunteer Board members that are community representatives, so we think we do a great job in identifying individuals that represent the community.

We're really focusing on making sure that

they're reflective of the community and trying to get more minority representation and others on our Board, but we feel that those individuals that are currently in place and the potential folks that are coming on board do reflect and bring that community representation, so I'm not sure what other suggestions you might have, but we think that they're incredible advocates for their communities and have done a really outstanding job over the years representing the community, so we feel we're in good shape, but I don't know whether, you know, what, specifically.

MR. HARTLEY: I think it's evidenced by the public testimony and the letters that are in our application. There is no apparent concern about the level of representation we have provided to the community in the past. We're remaining not-for-profit.

We continue to provide plenty of access to our community health and needs assessment and other activities to services and needs in the community and will continue to do so.

MR. DADLEZ: We also have many other avenues of community representation. For example, our Curtis Robinson Center for Health Equity has a very comprehensive Advisory Board that brings together leaders

in the community that are really focused on health equity and their issues. All that information bubbles up to the regional Board. All our local Boards have community representation, that, in addition, they focus on the quality, on the immediate local needs of those communities.

All that information comes up to the Board, so one of the things of a well-functioning Board is not to have an overwhelming volume of people on it, because you'll never get anything done.

You want to have the correct number of folks on there and make sure that you're really implementing the strategic direction for the community, so you don't want to overwhelm it, you don't want to overburden it, but you want to make sure all the correct information comes up to the regional Board, and I think that we're doing a very good job at it right now in my estimation.

MS. RIGGOTT: Thank you. With respect to a three-year service plan, are there concerns regarding submitting to OHCA a plan describing any consolidation reduction, elimination, or expansion of existing services, or introduction of new services?

MR. HARTLEY: Chris Hartley, St. Francis.

I think the issue here is threefold. One, it is a health service. What is a health service, and what are we talking about, and, also, recognizing the dynamic nature of health care right now, projecting today, and we will be happy to commit to what we're providing services now.

Without taking into account the changes that are rapidly occurring in the health care system, the changes in reimbursement, and, actually, the changes in the way we deliver health care potentially could lock in place services without service change that are not appropriate to do at this point in time, but, clearly, our intention is to continue to provide health services in this community over the three-year time frame that's talked about, but there's nothing magic about three years.

The issue here is to make sure that we do care in the right place, the right way, at the right time, and that's going to change over time, and it's going to be focused more and more on prevention and maintaining the total health of a person over time, so, yes, the concern would be artificially locking in place an ill thought out definition of health services that doesn't give us the flexibility to change with the way health care, itself, is changing in a rapid fashion.

As you know, some of the things that we've talked about today, even the input of the Community Health Needs Assessment, isn't available at this point in time. When this is finished and available, there may be some new areas that identify for us as part of that.

Clearly, the reimbursement changes that are going on have impacts and pressures on all health care providers, and working with others in the collaboration may change the way we deliver that health care in the future, and we've got to look at that and think of that as we go forward together, but, clearly, our intention remains to provide the health services that we have today tomorrow, but perhaps in a different way, and we can't predict all those ways at this point in time.

MS. RIGGOTT: Thank you. Any my last question involves the capital investment plan. Are there any concerns with submitting to OHCA within a specified time frame a capital investment plan, detailing a list of planned capital expenditures with descriptions and associated estimated costs and time frames?

MR. BITTNER: I think, with -- David Bittner. I think that any capital planning I think both our organizations, St. Mary's and Trinity Health, Trinity

Health New England, try to plan out capital in a three-year, five-year kind of time frame, however, even in a single year, it's hard to predict that the capital that we planned this year for next fiscal year that we'll spend all that capital exactly how we've outlined, those capital spends.

I think we've provided to OHCA in a series of reports those kind of capital expenditures that we kind of foresee, in terms of facilities, equipment, technology, as well as other kind of future opportunities that we haven't identified what those opportunities are.

We have provided, I think, at least in the last, next couple of years related to capital, but, from the specificity around which pieces of equipment or which facilities are those that I don't think we have -- able to commit to, simply because even when we have a fiscal year budget over a 12-month period, those change on a month-to-month basis, depending on availability of capital, what's happening with funding from the state and the federal side, as well, which really has a place hold on what and how much capital you can spend in a fiscal year.

MS. RIGGOTT: Thank you.

MR. DAVID FERNANDES: Hello. My name is

David Fernandes. I'm part of the OHCA staff. My questions will pertain to the intercompany system fees, and my first question is going to be would it be accurate to say that the incremental column within the financial Worksheet A, as submitted in the pre-filed testimony, does not include the Trinity Health New England intercompany fees?

MS. SCHNEIDER: Jennifer Schneider. With respect to the intercompany fees, there's a couple of different components, and the first is the system allocation, which is -- I think you've seen us reference it. It's a .8 percent of total operating expenses.

When we show the incremental savings of one percent, that was net of the 1.8, so those types of corporate fees really are to support all the things we've talked about here, evidence-based standards as we move forward, and it really gives the ministries access to those services and really that benefit.

There's another piece, as you see reference in the definitive agreement and other places in the submission, where it talks about shared services.

In those shared services, really we tap into those. They're more direct expenses, so once we start utilizing revenue cycle and other areas directly,

it's really, again, a one-for-one, so there's no incremental costs associated with either Trinity Health New England or Saint Mary's with respect to those, and those come on later, as we become more mature into Trinity Health and Trinity Health New England as the organizations move forward.

MR. FERNANDES: Thank you. My second question is can the Applicants at this time provide an estimated dollar amount for what the intercompany fee might be after the first year of the proposal?

MS. SCHNEIDER: So the intercompany fee, again, is the .8 percent of operating expenses, and it will be set at the Trinity Health New England level, so, you know, for Trinity Health New England, it will likely be about between eight and nine million for the entire system, and then it will be Trinity Health New England's responsibility to allocate that across all of the local hospitals and other entities within the organization.

MR. FERNANDES: Okay, thank you. Third question. Currently, what is Saint Mary's spending on the services that will now be covered by the intercompany fees?

MR. BITTNER: Well I think it's hard to quantify at this point, because there are certain I guess

operational costs that we just haven't been able to get to. Some of them are purposes for FTC reasons, but, as you look at Trinity's overall supply chain that Chad Wable had just mentioned, in terms of changing group purchasing organizations and having a group purchasing organization the size that Trinity Health has, bring supply chain savings to Saint Mary's, specifically, but, also, to Trinity Health New England.

In addition to that, they also maintain their own commercial insurance programs. Not only commercial insurance, but for property, casualty, general liability, malpractice. All those costs are self-insured by Trinity Health.

There's 90 hospitals with over $15 billion or $16 billion in revenue, so given that scope in size, so insurance costs related to Saint Mary's, supply chain costs, also treasury costs, when you start looking at cost of capital, the amount of investment return that one could have, when you're in a position like Trinity Health has been, St. Francis Care and Saint Mary's, as well, where you're subject to debt covenants around certain days cash on hand, you don't really have the luxury to invest a lot of your cash into the open market, because it doesn't -- it can't really suffice with the swings in

the market, so if you have an unrealized loss, it can put you in a position where now you no longer meet those covenants.

And, so, with Trinity Health, they actually put, they can actually put those investments in the market and earn an additional return, so it's not only a savings on expense perspective, but, also, it's beneficial interest or investment income that can be generated from the cash that's currently on hand at the respective organizations.

MR. FERNANDES: Thank you. My last question will be, other than the intercompany system fees, will Saint Mary's be required to make any other payment, either directly or indirectly, through the New England Regional Health Ministry to Trinity Health, Inc.?

MR. BITTNER: Well, at this time, there's no fees that I can tell you today that would occur and how some of those could change in the future.

I do think that, as we bring the region together, there will be shared services across the whole region, so there will be regional costs that will be held at Hartford, so revenue excellence, a revenue cycle, for instance.

What we're trying to work on is developing

a unified billing office, so if you're a patient, wherever you had gone within Trinity Health New England, you would get one patient bill for any service provided by any clinician, who is affiliated with our system, would go through a unified billing office, and that patient, then, is connected throughout the entire region through the electronic medical record.

So with that aspect, some of those services are corporate services, and those fees, then, would be charged up through the individual hospitals that they belong to, so Saint Mary's could have a regional fee, if you will, but all those fees would just be offset by the overhead cost reductions as the system kind of matures and achieves and climbs the scale throughout the region.

MR. FERNANDES: The billing service, is that included right now in the .08 percent?

MR. BITTNER: No, it's not.

MR. FERNANDES: So it potentially may be an increase, or there may be a potential like --

MR. BITTNER: There may be a price that goes, maybe a cost over to the regional system, but if you look at the cost currently for Saint Mary's to provide billing services, that actual cost would go down.

It would just be, instead of spending it on FTEs within the local area, it would be in a regional setting, so, actually, a reduction in the overall cost, itself, but it stays within the region.

MR. FERNANDES: Okay, thank you. That concludes my questions.

MR. RONALD CIESONES: Ron Ciesones, OHCA staff. My questions are going to start regarding some of the accounting methods and the financial stability of the organizations. They come from the interrogatories that were filed.

Regarding the statement of operations data for the first six months that were submitted with the pre-file, do you expect the financial performance would be similar in the second half of the year as with the first six months of activity?

MR. BITTNER: The short answer is, no, no. We expect operations to improve. September of 2015, the health system, both our health systems, actually, was really hit with the first kind of round of Governor Malloy's reductions and really forced us, and we at St. Francis Care had a budget ready to go in front of our Finance Committee.

We actually kind of tossed it. We kind of

restart the budget process over again, and that time that it took, basically, to respond to the reductions in reimbursement on the State and the Federal level I think took us at least that six months, and, as Chris has stated before and Chad, as well, what we've done is focus on productivity improvements, trying to look at the productivity of our staff, provide them tools and resources to better manage the staff and be able to flex up and down between where the volume is occurring with each of the patient floors.

That, and then working with Trinity Health to try to optimize some of the synergy, so it's taken us I think the first six months of the fiscal year to get in line a lot of those operating improvements and get in line some of the strategic initiatives that we wanted to put in place to make those improvements into the fiscal year, so that six months ending March we actually had significant improvements in our fiscal situation, were, actually, we had a $3 million gain as Trinity Health New England and then moving forward in the April, May, June, which completes the fiscal year for Trinity Health.

We expect the latter six months to improve significantly, and we're hopeful that we'll get the funding that the legislative body just approved in this

last special session back in December and, again, in May.

MR. CIESONES: Now your response is mostly regarding Trinity Health New England's piece, as to the finances?

MR. BITTNER: Yeah.

MR. BECKER: Ralph Becker. We are doing a little bit better this year than we have been. Volumes are up a little bit, so that's been helping, but do I see us doing as well in the last six months? Yes. I think we will continue doing as well as we are right now, again, subject to what happens with the provider techs.

MR. CIESONES: So would you say that the financial ?? that were submitted with the application would be accurate for the years 2017, '18 and '19, or would they need to be adjusted?

MR. BITTNER: That's our best estimate today. I think that assumes that we get some of the tax funding back that have been promised in the legislature, so, again, if the administration withholds the supplemental payments, so, for Hartford, for St. Francis, that's $40 million of taxes that we pay, so whatever supplemental payments we don't get, that kind of goes back into the overall tax, itself.

This assumes that we get at least what's

been estimated by the legislature, and it's our best estimate at this point in time.

MR. CIESONES: Throughout the application or the pre-file, rather, you, on pages 1025 and 1034, you reference cash flow from operations quite a few times for both St. Francis and Saint Mary's.

How come you use -- is there a reason that you use cash flow from operations, as opposed to operating income and losses from the statement of operations?

MR. BITTNER: Yeah, because the cash flow from operations kind of, before we actually make any kind of capital expenditures, so that's basically what the organizations bring in from a cash perspective before we actually expend it in other capital or other investments, so that's the indication of what we can generate just from an overall cash flow perspective.

MR. CIESONES: And would you be able to provide a supporting worksheet for the numbers that you have on both pages 1025 and 1034 for both St. Francis and Saint Mary's?

MS. SCHNEIDER: Jennifer Schneider. So you're just looking for supporting documentation to support those numbers?

MR. CIESONES: Right. There's St. Francis, 33.6 million.

MS. SCHNEIDER: We could provide that.

MR. CIESONES: Okay, thanks.

HEARING OFFICER HANSTED: Okay. I'll order that as Late File No. 1.

MR. CIESONES: My next question regards Saint Mary's pensions. That's noted throughout the pre-file. You noted that one of the -- once this was to go through, that you would like to bring the Saint Mary's pensions more -- fund more of the pensions, similar to Trinity. Do you have any procedures, methods to do that?

MR. BITTNER: I think there's an overall, I guess, philosophy, and that philosophy would be to fund it at the same levels as you mentioned before.

There's a lot of information that goes, a lot of variability that goes into that calculation, itself, so a discount rate, for example, so if you look at the current interest rate environment that we're in, it has a lot to do with what the overall pension obligation is going to be out in the future, so it has a huge impact on what the funding status is, so if you had a one percent increase in the discount rate, you could have an increase of funding status significantly just

from that one change in interest rate environments.

The second one is some of the demographic information related to the assumptions being used in the actuarial valuation, so a lot of those were just recently changed, both for Saint Mary's and organizations, I think, in the United States, actually, that has a significant impact on the overall pension obligation, how much that is.

The other piece is how well is the investments in the pensions doing within the market, itself. So if the market does significantly better than what your expectations are, then your funding status automatically goes up, without any additional contributions.

I guess, aside from that, there is an overall plan. Historically, Hartford has always funded the pension expense, and, so, that would be more of a minimum funding requirement from a personal perspective or how we kind of treat that historically, but anything above that we'd like to get to that 80 percent, plus, 80, 85 percent level of funding status, where, currently, at the end of FY '15, Saint Mary's was at 47 and a half percent.

And, so, that's both a combination of

change in discount rate, change in looking at the actual how the investment performance is doing, as well as contributions by Trinity Health, Trinity Health New England into the actual pension plan, itself.

MR. CIESONES: Do you see Trinity somehow taking a loan to bump up the funded status possibly?

MR. BITTNER: Possibly. That's always an option. That is one of which we're looking for with Trinity Health New England. With St. Francis Care, we're looking at a loan to help continue to fund our pension liability into the future, as well.

MR. CIESONES: The next couple of questions I have are regarding the capital commitment amounts for Trinity Health New England.

On page 1034, the previous responses indicate that the hospital spends roughly $12 million per year on capital expenditures or capital acquisitions, and Saint Mary's Health System projects to earn approximately 8 million per year from operations after the merger.

Why does -- considering that there will be a profit from operations, why does Trinity have to contribute the 54.7 million for Saint Mary's?

MR. BITTNER: A big portion, I think, of that, the $45.3 million is over a series of time, so,

over the five-year period, it's expected that there will be an operating income, which is that 45.3, so there's a $100 million commitment. The difference, then, is that 54.7, so what's hard to predict, in terms of either whether we forecast something two years out or three years out, is what's going to happen on a federal and state reimbursement perspective?

It's hard to predict, and I think, to a certain degree, as we try to even budget for even this year and last year, St. Francis I can speak for had made commitments to its employees to increase its across the board living adjustments.

We make commitments to fund defined contribution plans, of which, because of the promises that were made around the supplemental payments and the supplemental pools around the provider tax, itself, we made those commitments, but, then, once those were pooled, we still honored those commitments, knowing that there may be opportunities where the legislature comes back, and I think in this case, as well, I just look at the 45.3 million, some of the 54 that's got to be funded through intercompany debt is because it's anticipated that there are going to be issues, I think, on the state side, as well, and federal reimbursement, for that

matter.

MR. CIESONES: Also, on page 1034, will the operating losses that thus far in fiscal year 2016 for Trinity affect the funding for St. Francis' $158 million contribution from operating income from the same chart?

MR. BITTNER: Could you repeat that?

MR. CIESONES: On the chart, you have 158 million for St. Francis.

MR. BITTNER: In expected operating.

MR. CIESONES: Right.

MR. BITTNER: Right.

MR. CIESONES: On the financials that you submitted with the pre-file for the first six months shows Trinity Health with an operating loss of roughly 16 million?

MR. BITTNER: Right.

MR. CIESONES: Will that affect the $158 million commitment, the commitment that comes from operating?

MR. BITTNER: No. So, first of all, I'll just kind of mention, when St. Francis and Trinity Health got together, there was a $275 million kind of commitment over a five-year period of time.

You kind of see the breakout is 1,033, how we're looking at that 275 million amongst, and it has given us opportunities with Saint Mary's, Johnson Memorial Medical Center to kind of come together in this regional health system, so if Hartford, if St. Francis Care does not perform financially, then more money, then, would come from Trinity Health, in order to fund that commitment versus the funding of the commitment coming through hospital operations through income from operations.

I don't expect -- I think the 158 million is our best estimate of what our cash flow income is going to be over the next five years, considering what's happened with reimbursement, and that's kind of our best guesstimate.

It wouldn't impact, then, if we had losses, it may impact where we'd get more money from Trinity. If we got higher, the less money that we have to borrow from Trinity from a capital commitment perspective.

MR. CIESONES: I just have one last question. Would the operating revenues from one of the hospitals, whether it's Johnson or Saint Mary's, be used to fund capital improvements at another regional health

ministry hospital?

MR. BITTNER: Within Trinity Health New England? Are you asking if it could?

MR. CIESONES: Yes.

MR. BITTNER: Yes, it could.

MR. CIESONES: So money can kind of flow in between the three hospitals?

MR. BITTNER: Yeah. If one hospital is much more successful than another hospital, then definitely, if there's a need from a community perspective, then that hospital would have the funding it needs to support those programs and services, and one of the pillars I think Trinity Health has and Trinity Health New England is commitment to those, who are poor, and, so if one hospital is struggling to fulfill that commitment and the other one is doing very, very well, then some of that operating income would go to actually improve the other's performance and continue those other services.

MR. CIESONES: So the three will kind of all be working together?

MR. DADLEZ: Well you're seeing that right now, for example, at Johnson Memorial. We're providing substantial support to Johnson right now while it's getting its feet on the ground and restructured, so,

obviously, that has to happen.

When we're trying to do is evolve from this old school hospital enterprise to a total health care operating company that's responsible for developing the right services in the right place at the right time for the entire region, so we'll be investing in ambulatory care development that might be between Hartford and Waterbury. We'll be investing in ambulatory development between ourselves and Johnson Memorial.

So the whole world is changing, and how we invest our dollars is really focused at how do we create the best system we can for the people that we serve?

And, so, it will be somewhat fungible, but we want to take care of the locations, because the hospitals right now, you know, they have to be successful and drive a lot of business, but we're trying to evolve in this case, and capital investment is going to depend on how the whole health care enterprise evolves, if that makes sense.

MR. CIESONES: That's all I have for questions.

HEARING OFFICER HANSTED: Before OHCA continues with its questions, I understand we have a senator that would like to give public comment.

(Whereupon, Joan Hartley gave public comment.)

MS. SCHAEFFER-HELMECKI: Hi. Good afternoon. So I'd like to ask a few more questions about the capital commitment and, specifically, how you expect it to be apportioned among the different regional health ministry entities.

And, as a basic question, firstly, are the amounts of capital expenditure allotted to each hospital maximums or minimums?

MR. BITTNER: Minimums.

MS. SCHAEFFER-HELMECKI: Now during the public hearing associated with St. Francis' application, 15-31979-CON, Trinity stated that at least 195 million of the $275 million pool of capital expenditures would be committed to St. Francis Hospital, specifically. Is that correct? I believe it was actually your testimony, Ms. Schneider.

MS. SCHNEIDER: Well I have to locate it.

MS. SCHAEFFER-HELMECKI: It was on page 33 of the transcript. I believe it was the portion that we took administrative notice of.

MS. SCHNEIDER: That's correct. So if you note there, it says 195, specific to St. Francis Hospital

capital acquisitions, whether it's upgrade to facilities, medical appointment, other areas that have been identified.

And I think, when we speak about, you know, the upgrades and the capital acquisitions, that can be inclusive of the St. Francis system.

MS. SCHAEFFER-HELMECKI: Okay and I believe you later said that it was specifically for entities already affiliated with St. Francis on that July 1, 2015 hearing, although there was 48 million allocated for other future associations.

MS. SCHNEIDER: Correct. That is correct.

MS. SCHAEFFER-HELMECKI: Great. So, in your responses to the completeness questions, you also stated that, at the time of the St. Francis hearing, again, July 1st, that you knew Trinity and Saint Mary's would seek to merge.

That being said, why has St. Francis' capital commitment been reduced from 195 million to possibly 142 million?

MS. SCHNEIDER: So I think, again, to David's point earlier, it's the minimum capital commitment, and I think it's really the 162 million is specifically a minimum to St. Francis. Oh, sorry. Page

1034.

MS. SCHAEFFER-HELMECKI: Excuse me. What was that on page 1034?

MS. SCHNEIDER: 1034, up at the top, the total capital expenditures, total funding. We were asked, I think, to show, to demonstrate how the 275 could be allocated, and we talk about the 100 million minimum to Saint Mary's, 13 million to Johnson, and 162 million to St. Francis, and, again, these are the minimums.

MS. SCHAEFFER-HELMECKI: Maybe I misunderstood, but I thought that was the source of the funding, where the money was coming from, not where the money was going on page 1034, so are you referencing 1033?

MS. SCHNEIDER: Correct. Which rolls over to 1034.

MR. BITTNER: Let me just mention, so, when Trinity Health and St. Francis Care came together, it formed Trinity Health New England, and, so, a $275 million capital commitment went to Trinity Health New England, of which then it's utilized to that capital commitment to help with the acquisition of Johnson Memorial Medical Center on January 1, 2016, and then now, as Saint Mary's have come together, it's provided the

necessary capital to provide a commitment.

St. Francis Care on its own wouldn't have the ability to be able to commit those kind of funds without a partner like Trinity Health, so that 275 was at Trinity Health, so St. Francis Care on October 1st became Trinity Health New England.

MS. SCHAEFFER-HELMECKI: So you're saying there was no money allocated to a specific entity, and you're saying it was just a general pool of 275, and the allocation that was submitted as part of the application was not indicative of how the money was actually to be spent?

MR. BITTNER: No. The 275 was allocated to Hartford within Trinity Health. It formed Trinity Health New England, so Trinity New England then became the entity in which, for the Hartford office, then, of which it could spend or have commitments of that 275 million over a five-year period of time.

MS. SCHAEFFER-HELMECKI: But at the time of the application, St. Francis Hospital was St. Francis Hospital, so references to money allocated to St. Francis Hospital was the hospital and not St. Francis Care or what is now the Regional Health Ministry, correct?

MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, great. All right, so, just to return to that $48 million, that was unallocated originally, so, at the time, you did state that you believe that Johnson's capital expenditures would probably come out of that 48 million, as it was an organizational priority, correct?

MS. SCHNEIDER: That is correct.

MS. SCHAEFFER-HELMECKI: And then, also, you stated that St. Francis, so, like you anticipated the Saint Mary's merger, and I still am not seeing exactly why there wasn't money allocated in that 48 million for Saint Mary's, because now we're looking at a capital expenditure for other entities of between 113 million and 133 million, which that seems like a fairly significant departure from the 48 million that you had set aside originally, so I don't understand. I guess I'm not seeing why there wasn't more money set aside.

MS. SCHNEIDER: I think, at that point, it was really the timing and where we were in the maturity of the discussions with Saint Mary's, in terms of being able to specifically allocate anything at that point in time.

MS. SCHAEFFER-HELMECKI: So now the change in the Saint Francis, excuse me, Saint Francis Hospital

allocation is about between 65 and 85 million difference than what was initially projected to be spent on capital there.

What projects, if any, will be eliminated or modified at St. Francis as a result of that change?

MS. SCHNEIDER: I think, going back to David's point around our capital strategy, we really look at three years. We try to plan three years. It's even difficult, so there's nothing that we're aware of that would not happen.

And, again, this is the minimum commitment, as we continue to identify strategic initiatives and necessities within the local hospitals that are part of the ministry.

Those would be our priorities, and if we needed access to capital, we would, then, move forward as part of the capital management process within Trinity and see if we could get funding for those if our operating income and our current cash flows could not support that, but there's nothing, I think at this point, that I'm aware of that would be delayed or not fulfilled, based on any of these changes, specific to St. Francis Hospital.

MS. SCHAEFFER-HELMECKI: And at what point would you know what the capital expenditure plan is at

St. Francis if anything is changing?

MS. SCHNEIDER: So we are in the process of doing our capital budget right now for fiscal '17, which we will manage and report I think as of July 1 fiscal year, and, at this point, everything that's included in our capital plan is going to, you know, Trinity Health for insurance.

It's aligned with the strategy, and we would hear, and we don't believe, and we've heard nothing to lead us to believe that that wouldn't continue to be our plan for fiscal '16. '17.

MS. SCHAEFFER-HELMECKI: So, now, if there are any additional entities that are acquired by Trinity in the future that become part of the Regional Health Ministry, would that in any way alter the amount available to Saint Mary's for capital expenditures?

MR. BITTNER: I think that the 100 million or 120 million, depending on how Saint Mary's performs, there may be opportunities that Saint Mary's finds within the community within Waterbury for investment opportunities that may go against that $100 million.

So, if you look at their current operations now, there's a lot more investments that have to occur, I think, in the future, whether that's the

acquisition of ambulatory strategies ?? the community.

That could further -- I mean that's an investment of capital, right? So that goes against the $100 million, I guess you'd say, if it's related to the ambulatory strategy around the Waterbury market.

So I think, from a capital perspective, we tend to look at this from a more global perspective around Trinity Health New England and the region and how we provide health care services around the region, as well.

I can say that, as we mentioned before, these are minimum requirements, so if there's opportunities within the state, within the region that are good opportunities from an economic perspective, that those would be funded by Trinity Health, but those go to a separate Board at Trinity Health or a separate committee, of which Chris sits on, as well, that helps to allocate the overall resources that Trinity Health has from an investment perspective.

MS. SCHAEFFER-HELMECKI: So that's a, yes, it could change, but it's a minimum? You're saying that 100 million is an absolute floor, and regardless of any entities acquired in the next five years, there's a guaranteed $100 million commitment?

MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, thank you. Okay, I have just one last set of questions. Prior to Trinity's acquisition of St. Francis, how much was St. Francis spending each year on average on capital investments.

MS. SCHNEIDER: Between 35 and 38 million on average prior to. The more recent years were a little bit higher with our investment in the Epic implementation, so prior to those two years, it's probably closer to 30 million, but, more recently, about 35 to 38.

MS. SCHAEFFER-HELMECKI: Yeah. I think we had 39, the number that had been stated several times, so that seems accurate.

Based on your projections of spending between 142 and 162 million in capital at St. Francis over the next five years, that works out to an average of between 20.4 million and 32.4 million per year.

Are you projecting a decline in capital spending at St. Francis compared to its spending prior to joining Trinity?

MS. SCHNEIDER: No. Again, that would be the minimum, and the budget currently, going into fiscal

'17, is just under 40 million as it stands today. Again, there's a lot of regulatory pressures and other financial issues we're dealing with, so it's not approved yet, but it's higher.

MR. DADLEZ: An example of that is, because we keep stressing minimum, minimum, I mean this is the bottom threshold, in the Springfield market, for example, which doesn't deal with Connecticut, Trinity just funded the purchase of a 200-member physician group, River Bend Physician Group in that region, and over and above, way over and above the capital commitments that is made on an annual basis to assistance of Providence health system, so the commitment is to do what's right for the community, and if there are opportunities to develop and grow, Trinity's commitment is to fund that.

We're very quickly becoming one of the largest, if not the largest regional ministry in the nation, and they want us to grow and develop.

The intent is for us not to squeeze dollars out of this region, but to strategically grow it and make it stronger, so I frankly and firmly believe that there's a commitment to do more, not less, so, in my mind, there's no way that it will be less than what we've traditionally spent.

MS. SCHAEFFER-HELMECKI: Okay, great. Thank you.

MR. DADLEZ: Okay.

HEARING OFFICER HANSTED: All set? Okay. That concludes OHCA's questioning.

At this point, I want to ask one more time is there anybody here that would like to give public comment that has not had an opportunity to do so?

I don't hear or see anyone. It's only 5:30 at this point. What I'd like to do is give members of the public an opportunity to get out of work and actually travel here, if they choose to do so, so we will adjourn until 6:00 p.m.

At that time, we'll go back on the record to see if there's any more public comment, so, at this point, we're adjourned until 6:00 p.m.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're back on the record. It's now 6:00 p.m. One last time, is there anybody here that would like to give public comment on the proposal before us?

Hearing and seeing none, I would like to thank everyone for attending, and this hearing is adjourned.

(Whereupon, the hearing adjourned at 6:00 p.m.)

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CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 18th day of May, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, May 17, 2016 8:09 AM
To: Hansted, Kevin; Riggott, Kaila; Fernandes, David; Ciesones, Ron
Cc: Greer, Leslie; User, OHCA
Subject: FW: 15-32045-CON Saint Mary's Late File
Attachments: Late File DN 15-32045-CON.pdf; 15-32045 Late File Last 12 months EBIDA.xlsx; 15-32045 Late File St Mary proj cash flow.xlsx

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From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Monday, May 16, 2016 1:28 PM
To: Schaeffer-Helmecki, Jessica
Cc: Hartley, Christopher; Rotavera, Liz; Attorney Bob Anthony; Joseph Connolly - St. Mary's Hospital (jconnolly@stmh.org); Schneider, Jennifer
Subject: 15-32045-CON Saint Mary's Late File

Hello Jessica…Attached are pdf and excel documents in response to the late file request from the Saint Mary's and Trinity Health – New England May 10th public hearing.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

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Trinity Health - New England
15-32045 Late File
Last Twelve months EBIDA Calculation (Cash Flow from Operations)

Saint Francis/Trinity Health - New England

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Last 12 Months
Total Net Revenue	70,908	68,835	67,628	73,123	65,819	66,555	70,731	67,707	70,228	71,812	63,916	81,047	
Operating Income	1,943	664	(3,149)	3,583	(1,341)	(5,335)	(37)	(4,928)	(4,938)	(4,977)	(4,540)	2,908	
Excess Rev over Exp	2,349	1,499	7,607	3,847	(2,439)	(15,682)	(2,748)	(4,132)	(5,365)	(4,675)	(5,120)	5,212	
EBIDA	6,057	4,898	1,093	7,827	2,883	(1,012)	4,107	(733)	(816)	(598)	(362)	10,208	**$ 33,552**
EBIDA Margin	8.54%	7.12%	1.62%	10.70%	4.38%	-1.52%	5.81%	-1.08%	-1.16%	-0.83%	-0.57%	12.60%	

Saint Mary's

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	
Total Net Revenue	25,399	24,762	26,024	23,996	22,395	22,894	25,030	23,818	25,404	26,825	27,089	28,303	
Operating Income	539	283	1,500	(859)	(1,052)	(358)	(594)	(443)	1,637	925	203	1,967	
Excess Rev over Exp	578	519	1,846	(386)	(550)	(1,646)	(631)	(492)	2,404	772	339	1,807	
EBIDA	1,608	1,278	2,361	151	(26)	869	416	615	2,714	1,960	1,239	2,985	**$ 16,172**
EBIDA Margin	6.33%	5.16%	9.07%	0.63%	-0.12%	3.80%	1.66%	2.58%	10.68%	7.31%	4.57%	10.55%	

Total

Source: internal financial statements.

Saint Mary's Health System
Future Cash Flows for Capital Acquisition after Debt Service
15-32045 Late File

	(4) FY 2016 Projected With CON	(7) FY 2017 Projected With CON	(10) FY 2018 Projected With CON
Per Worksheet A Page 1012 of CON EBIDA	**$16,299** **5.4%**	**$18,755** **6.0%**	**$21,087** **6.6%**
Less: Principle Payments (Line 33 of worksheet A)	$3,000	$3,000	$3,000
Cash available for Capital Acquisition after debt payments	**$13,299**	**$15,755**	**$18,087**
Amounts reported on page 1025 of CON	**$13.3**	**$15.6**	**$18.1**

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Wednesday, June 01, 2016 8:53 AM
To: Attorney Bob Anthony; Hartley, Christopher
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: 15-32045 Close of Hearing
Attachments: 15-32045 Close of Hearing signed.pdf

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 1, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry
Closure of Public Hearing

Dear Mr. Hartley and Mr. Anthony:

Please be advised, by way of this letter, the public hearing held on May 9, 2016, in the above referenced matter is hereby closed as of June 1, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Jessica Schaeffer-Helmecki at (860) 509-8075, Ronald Ciesones at (860) 418-7030, or David Fernandes at (860) 418-7032.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH:jssh

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Wednesday, June 01, 2016 8:54 AM
To: Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: RE: 15-32045 Close of Hearing

Thank you for your help in this important endeavor.

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Wednesday, June 01, 2016 8:53 AM
To: Attorney Bob Anthony; Hartley, Christopher
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: 15-32045 Close of Hearing

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
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Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, July 27, 2016 4:08 PM
To: 'BAnthony@Stmh.org'; Hartley, Christopher (CHartley@stfranciscare.org)
Cc: Schaeffer-Helmecki, Jessica; Fernandes, David; Ciesones, Ron; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: DN: 15-32045-CON Agreed Settlement
Attachments: 32045 Agreed Settlement.pdf

Attached is the Agreed Settlement for DN: 15-32045-CON.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants:

Saint Mary's Health System, Inc.
56 Franklin Street
Waterbury, CT 06706

Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152

Trinity Health–New England, Inc.
114 Woodland Street
Hartford, CT 06105

Docket Number: **15-32045-CON**

Project Title: **Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health–New England**

Project Description: Saint Mary's Health System, Inc. ("SMHS"), Trinity Health-New England, Inc. ("TH-NE") and Trinity Health Corporation ("THC"), herein collectively referred to as the ("Applicants"), seek authorization to transfer ownership of SMHS and its subsidiaries to THC and TH-NE.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the *Republican American* (Waterbury) on October 22, 23 and 24, 2015. On November 25, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on April 5, 2016.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

On April 18, 2016, the Applicants were notified of the date, time, and place of the public hearing. On April 20, 2016, a notice to the public announcing the hearing was published in the *Republican American*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on May 9, 2016.

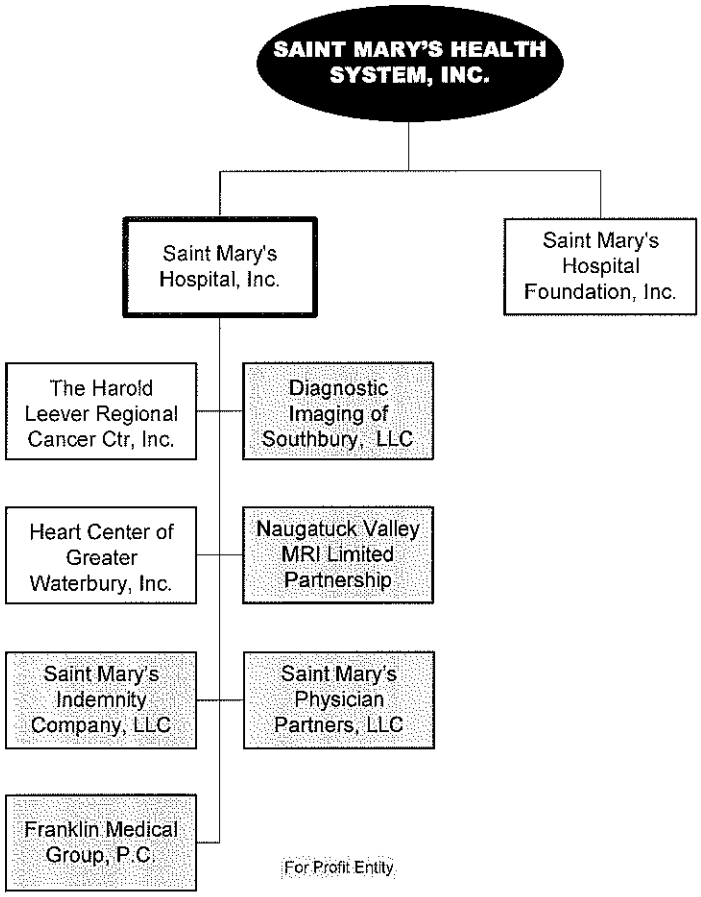
Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a.

The record was closed on June 1, 2016. Deputy Commissioner Addo considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. SMHS is a not-for profit, integrated Catholic health care delivery system serving the greater Waterbury area. Ex. A, p. 18.

2. SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliated entities (see legal chart of corporate structure, below). Department of Public Health, Office of Health Care Access, 2015, *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2015*; Appendix AA.



3. The Hospital is a 347-bed Catholic acute care hospital. It is designated as a Level II Trauma Center and provides a full range of inpatient, outpatient and ancillary services to residents of Waterbury and surrounding towns. Ex. A, p. 18.

4. The Hospital's primary service area is comprised of 16 towns. The Hospital's service area will remain the same as a result of this proposal. Over half of all inpatients in fiscal year (FY) 2015 were Waterbury residents (see table below).

TABLE 1
SAINT MARY'S HOSPITAL FY2015
PRIMARY SERVICE AREA TOWNS

Primary Service Area	
Town*	**Discharges (FY 2014)**
Waterbury	58.75%
Naugatuck	9.18%
Wolcott	6.25%
Prospect	3.34%
Total	**77.52%**

*Listed in descending order of discharge volume.
Ex. A, pp. 32-33; Ex. A, p. 289.

5. In anticipation of health care industry changes and federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to an accountable care organizations ("ACO") focused on population health management. SMHS determined that a strategic partner would bolster its ability to effectuate its Strategic Plan. Ex. A, pp. 22-23.

6. The need to address the following factors also prompted the Hospital to seek a partnership with another health care system:
   - Increased costs associated with quality improvements,
   - The growth of physician partnerships and the need for additional expertise in the management, staffing, data analysis and clinical oversight of a larger physician enterprise,
   - Necessity of expertise in clinical service redesign to utilize the latest clinical techniques,
   - SMHS's intent to expand upon its integrated accountable care organization
   - The financial capital required to meet the medicals records standard of the Patient Protection and Affordable Care Act ("PPACA"),
   - Development of a plan to address pension and other debt obligations, and
   - An aging infrastructure and the need to provide health services to the community as reflected in the Community Health Needs Assessment ("CHNA").

   Ex. A, pp. 22-24; Ex. E, p. 874; Ex. L, pp. 1026-1032.

7. SMHS created the SMHS Board-Appointed Taskforce ("Taskforce") more than a decade ago to assess potential partners based on a set of criteria including each candidates philosophical principles and adherence to a complementary set of religious directives; financial strength and ability to assist in satisfying SMHS's pension liability; provision of resources to improve technology at SMHS; and opportunities to recruit and retain staff. Ex. A, pp. 26-27; Ex. L, Prefile Testimony of Robert Mazaika, Chairman of the Board, SMHS, pp. 1062-3.

8. SMHS found THC and TH-NE to have a strategic plan and values very similar to its own, while sharing a common vision, philosophy and mission that preserves the Catholic health care tradition. Ex. A, pp. 22-23; 27.

9. Following the recommendation of the Taskforce, SMHS's full board approved a strategic alliance and a membership transfer agreement was signed on September 19, 2015. Ex. A, pp. 22-23; 27.

10. As a result of this agreement, the Applicants are requesting approval to transfer ownership of the Hospital and its subsidiaries to THC in order to become part of TH-NE. Ex. A, pp. 20, 27.

11. THC is a Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs across 21 states. It is the sole shareholder of TH-NE. Ex. A, p. 19.

12. TH-NE is the parent company of other health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford. Docket Number 15-31979-CON. Ex. A, p. 19.

13. The focus of TH-NE's organizational structure is to create a system that meets PPACA's objectives of improving population health, enhancing the patient care experience and controlling cost, while maintaining a positive financial margin. Ex. A, p. 24.

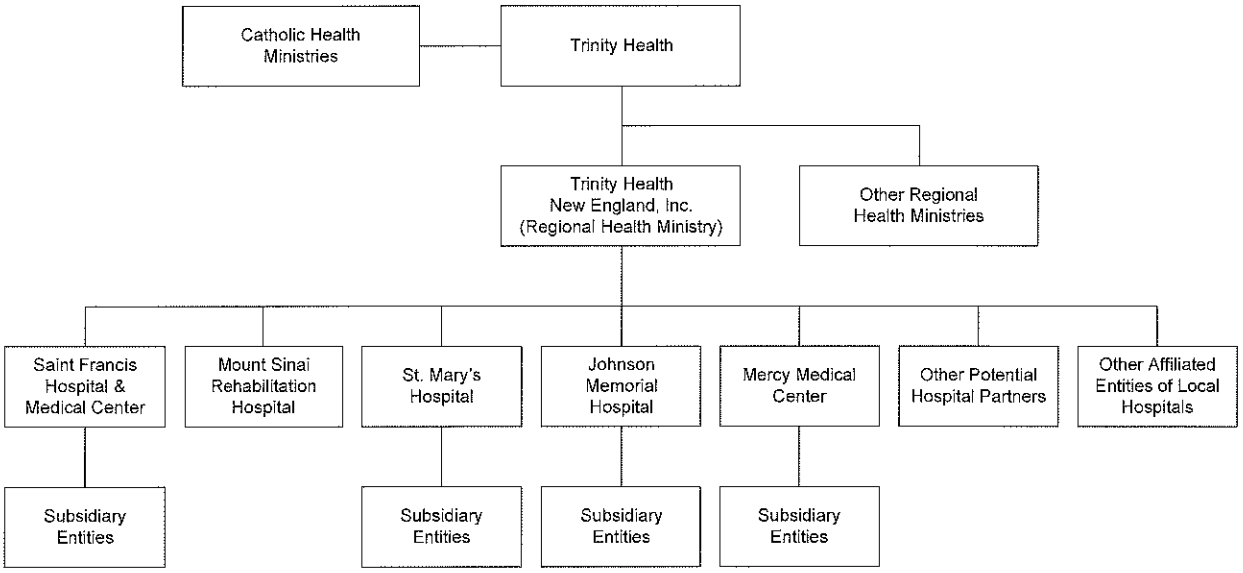
14. THC's key growth initiatives aim to align with organizations to strengthen the Catholic health care mission and to expand the system "footprint" to create an integrated ACO in each of its markets. Ex. A, p. 20.

15. THC has established a Unified Clinician Organization ("UCO"), a data and evidence-based infrastructure to align and support clinicians across the THC system, in an effort to advance a culture of safety, best practices, quality, patient satisfaction and high reliability. THC's accomplishments as a result of implementing its UCO initiatives include:
    - Decrease in sepsis mortality rate from 15.8% to 11.2% between FY 2010 and December 2014, resulting in 2,328 saved lives;
    - Elimination of vaginal birth after cesarean section "serious reportable events" following 2009 policy implementation;
    - Decrease in elective deliveries before 39 weeks from 4.7% from 2010 to 0.5% in 2015;
    - Consistent medication reconciliation composite score (both admission and discharge data) of 88% in FY 2015 to date;
    - Decline in pressure ulcer rates from 3.8% in FY 2008 to 0.01% in January 2015;
    - Lower than expected severity adjusted mortality rate (83%) in FY 2015;
    - Elimination of retained sponges in FY 2014 post-sponge accounting implementation; and
    - Improvement in safety checklist perfect patient score from 48% in January 2013 to 81% in July 2014.

    Ex. A, pp. 44-46.

16. To combat the substantial costs of hospital readmission, THC developed a post-acute care affiliated network that links a hospital to the continuum of post-acute providers. The result was a more accurate and efficient transition of patients from the hospital to the next level of care reducing readmission. Ex. A, pp. 52-53.

17. It is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. The following illustration depicts the organizational chart of the Applicants following the proposed transaction.



Ex. A, p. 163; Ex. E, p. 865.

18. SMHS's existing Bylaws and Certificate of Incorporation will be amended and restated so that TH-NE is the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. Ex. A, pp. 20, 112.

19. The Applicants propose adding two board members, appointed by THC for a period of three years to the TH-NE Board of Directors. The Hospital's governing board will remain unchanged other than the addition of the CEO of TH-NE. The governing board of the Hospital will be comprised of:
    - A representative of the member, designated by the member;
    - At least one physician; and
    - Members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community.

    Ex. A, pp. 20-21; 70-71; 113; Ex. E, pp. 900-901.

20. The Hospital's board will have community representation that will have the ability to pass on quality concerns and local community health needs to the regional governing board. Testimony of Mr. Dadlez, Ex. N, pp. 40-41.

21. There are no planned changes to the clinical services or location of any clinical services currently being offered by the Hospital. However, following implementation of the proposal, an "efficiency analysis" will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize the processes. Ex. A, pp. 21-22; Ex. E, p. 875.

22. For three years following implementation of the proposal, the existing SMHS Board's approval will be required prior to the termination or material reduction of any existing clinical services. Ex. A, p. 16.

23. The proposal does not involve any new equipment. There is no capital cost associated with the Transfer Agreement between the Applicants. Ex. A, pp. 21-22; Ex. E, p. 875.

24. The affiliation with TH-NE is intended to allow the Hospital to access experts in all clinical service lines and support platforms, and enhance its service delivery approach and systems. Ex. A, p.41.

25. The partnership between the Hospital and THC is also expected to result in access to resources of a large system at both the regional and national levels which will:
    - Help develop more preventive and primary care service programs, the need for which is identified in the 2014 CHNA;
    - Meet the demands of the 2010 PPACA, which requires an emphasis on value rather than volume in terms of reimbursement;
    - Provide access to readily available capital and financing at favorable interest rates; and
    - Assist in developing a plan to adequately fund SMHS's pension plan obligations. Ex. A, pp. 24-25.

26. The Health Resources and Services Administration has designated Central Waterbury as a medically underserved area and medically underserved population. Ex. A, p. 35.

27. TH-NE's CHNA and Strategic Implementation Plan ("SIP"), to be published in June 2016 and November 2016, respectively, will integrate the community health care priorities and strategies identified in SMHS's current CHNA. Ex. A, pp. 80-81; Ex. L, pp. 1031-1032.

28. The CHNA, developed by SMHS in conjunction with the Greater Waterbury Health Improvement Partnership, identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement for the Waterbury area. Greater Waterbury Health Improvement Partnership, *Community Health Needs Assessment Final Summary Report* 45 (Sept. 2013). Ex. A, p. 233.

29. To address chronic health conditions, THC will use community outreach to implement its Community Health and Well-Being Strategy, which emphasizes reducing the number of uninsured, recruiting multi-cultural and multi-lingual input from the community, prioritizing obesity prevention and tobacco control and transforming safety net care. The Hospital's current strategic focus area, in an effort to align its focus with that of the Connecticut Hospital Association, also addresses asthma in the community. Ex. L, p. 1030; Testimony of Mr. Connolly, Ex. N, pp. 23-25.

30. The SIP will follow the recommendations of the CHNA. Testimony of Mr. Connolly, Ex. N, p. 25.

31. The Hospital will be supported with resources in the form of regional and national experts to participate in national initiatives from the corporate headquarters of THC. Testimony of Mr. Dadlez, Ex. N, pp. 25-26.

32. SMHS currently leases space to Connecticut Children's Medical Center to provide inpatient services and the Hospital will continue to so following implementation of the proposal. Ex. A, pp. 39-40.

33. Following implementation of the proposal, TH-NE and Waterbury Hospital will work collaboratively to ensure the continued coordination of services provided by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury. Ex. E, p. 865.

34. Existing referrals patterns will remain unchanged. Ex. A, p. 57.

35. The Hospital will continue to operate for the benefit of the community and serve the poor and underserved, including supporting wellness, health education and other community programs, participating in medical research and governmental health care programs and identifying gaps in services in the community. Ex. A, p. 114.

36. The transfer of ownership will be complete by 10/1/2016. Ex. A, p. 70.

37. Overall volume for the Hospital fluctuated slightly from FY2012 through FY2015. Inpatient volume is projected to decrease .5% each year from FY2017 through FY2019 due to an expected continued shift of services performed as outpatient procedures.

TABLE 2
SAINT MARY'S HOSPITAL HISTORICAL DISCHARGES

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Medical/Surgical (Adult)	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

TABLE 3
SAINT MARY'S HOSPITAL HISTORICAL PATIENT DAYS

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Medical/Surgical (Adult)	41,395	41,900	40,663	40,360
Maternity	2,775	2,609	2,855	2,775
Psychiatric	3,994	4,099	3,933	4,139
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,390	1,303	1,240	1,227
Newborn	2,022	1,922	2,173	2,055
Total	**51,576**	**51,833**	**50,924**	**50,556**

TABLE 4
SAINT MARY'S HOSPITAL CURRENT & PROJECTED DISCHARGES BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Medical/Surgical (Adult)	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

TABLE 5
SAINT MARY'S HOSPITAL CURRENT & PROJECTED PATIENT DAYS BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2018
Medical/Surgical (Adult)	40,900	40,645	40,392	40,140
Maternity	2,914	2,914	2,914	2,914
Psychiatric	3,769	3,769	3,769	3,769
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,220	1,220	1,220	1,220
Newborn	2,228	2,228	2,228	2,228
Total	**51,031**	**50,776**	**50,523**	**50,271**

Ex. A, pp. 71-75.

38. Medicaid is the primary payer for nearly a third of the patients served by the Hospital. The Applicants do not anticipate any significant changes in payer mix as a result of this proposal.

TABLE 6
SAINT MARY'S HOSPITAL CURRENT & PROJECTED PAYER MIX[1]

Payer	Most Recently Completed FY2015		Projected							
			FY2016		FY2017		FY2018		FY2019	
	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%
Medicare*	5,289	45%	5,313	45%	5,276	45%	5,240	45%	5,214	45%
Medicaid*	3,703	31%	3,696	31%	3,683	31%	3,671	31%	3,653	31%
CHAMPUS & TriCare	22	0%	22	0%	22	0%	22	0%	22	0%
Total Government	**9,014**	**76%**	**9,031**	**76%**	**8,981**	**76%**	**8,933**	**76%**	**8,888**	**76%**
Commercial Insurers*	2,601	22%	2,613	22%	2,604	22%	2,594	22%	2,581	22%
Uninsured	103	1%	102	1%	102	1%	101	1%	100	1%
Workers Compensation	129	1%	129	1%	129	1%	129	1%	128	1%
Total Non-Government	**2,833**	**24%**	**2,844**	**24%**	**2,835**	**24%**	**2,824**	**24%**	**2,810**	**24%**
Total Payer Mix	**11,847**	**100%**	**11,875**	**100%**	**11,816**	**100%**	**11,757**	**100%**	**11,698**	**100%**

*Includes managed care activity
[1] Fiscal year is October through September
[2] Volume equals equivalent discharges
Ex. A, p 63.

39. There will be no changes in services for indigent or Medicaid recipients. Ex. A, p. 48.

40. The Hospital's policies, procedures and guidelines on charity care and financial assistance policies will be reviewed to ensure compliance with the new Internal Revenue Code Section 501(r) requirements effective January 1, 2016. Ex. A, p. 82; Ex. E, p. 870.

41. The Hospital's charitable policies are consistent with those of both THC and TH-NE Ex. E, p. 870; Testimony of Mr. Hartley, Ex. N, p. 31.

42. Saint Mary's Hospital Foundation, Inc. will continue to be a separate endowed foundation supporting the Hospital and the Hospital's subsidiaries. The Hospital will continue to comply with existing donor restrictions of the Foundation. Ex. A, p. 17; 114.

43. The Hospital will retain all assets and property currently belonging to SMHS. Ex. A, p. 21.

44. There are no planned changes to existing reimbursement contracts or billing practices between the Applicants and payers as a result of this proposal. Ex. A, p. 83; Ex. E, p. 865.

45. The Hospital will have access to TH-NE's internal Value Analysis Committee and its group purchasing agreements providing advantageous pricing for products and supplies. Ex. A, p. 53, 85.

46. The most recent credit ratings for THC are as follows:
    - Fitch (December 2015): AA/Negative Outlook;
    - S&P (December 2015): AA-/Stable Outlook; and
    - Moody's (December 2015): Aa3/Stable Outlook.

    Ex. E, p. 871.

47. THC and TH-NE have agreed to ensure the expenditure of $100 million for capital expenditures at the Hospital and its current subsidiaries over the next five years following the closing date. If specific performance metrics are met in the 3rd and 4th year following the close of the transaction, an additional $10 million of committed capital in both the 4th and 5th fiscal year will be available. Ex. A, p. 21; Ex. E, p. 866.

48. The $100 million capital commitment, and additional $20 million if certain metrics are met, will be part of the $275 million capital commitment THC made to the recently formed TH-NE. THC is responsible for the $275 million capital commitment to TH-NE with TH-NE being responsible to ensure $120 million of the capital is allocated to the Hospital and its current subsidiaries. Ex. E, p. 866; Ex. G, p. 1018.

49. The funding sources of THC's $100M capital commitment will be:
    - Available cash and investments generated by the hospital;
    - Financing obtained through the THC system debt program; and
    - Capital contributions from THC, to the extent necessary.

    Ex. A, p. 116; Ex. E, p. 866.

50. The Hospital's annually budgeted $12 million for routine capital purchases is included in the $100 million capital commitment from TH-NE. Ex. E, p. 869.

51. Operating revenue from one hospital could be used to help fund capital improvements at another hospital within TH-NE, if a hospital is unable to raise the needed capital through its own operations. Testimony of Mr. Bittner, Ex. N, pp. 59-60.

52. The commitment of $100 million for the Hospital and its subsidiaries will not be reduced if future acquisitions were to take place. Ex. G, p. 1017.

53. The table below provides a preliminary capital investment plan for the Hospital. Approximately $40 million is for routine capital needs while the remaining $60 million is for strategic investments.

TABLE 7
PRELIMINARY CAPITAL INVESTMENT PLAN FOR THE HOSPITAL (IN THOUSANDS)

Description	Five Year Total
Hospital facility upgrades	$ 22,000
Replacement of clinical equipment	$18,000
Information Technology & Electronic Health Records	$12,000
Urgent Care / Ambulatory Care	$10,000
Ambulatory pavilion on campus	$25,000
Conversion to private patient rooms	$8,000
Clinically integrated network development	$5,000
Total estimated capital expenditures	**$100,000**

Ex. A, p.82.

54. The Hospital will have access to THC's intercompany loan program, if necessary, to develop a health information technology exchange (HITE) and electronic health records system. Ex. A, p. 31.

55. The Hospital will be subject to an annual intercompany system fee by TH-NE one year from the close of the transaction to help cover shared system office services. The shared resources include the departments of revenue, treasury, human resources, supply chain management and information technology. This will reduce the need for members of the TH-NE to use outsourced accounting, legal and consulting firms. Ex. E, p. 873-874; Ex. G, p. 1016-1017.

56. The shared system office services and resources-- and concomitant fee-- may increase to include additional resources and services in the future. Testimony of Mr. Bittner, Ex. N, pp. 49-50.

57. THC charges TH-NE 0.8% of operating expenses for providing the shared system office services. TH-NE will allocate the charge among its member hospitals and other subsidiaries. The fee will be determined based on the members 'comparative use of the system resources. Ex. G, p. 1016; Ex. L, pp. 1032-1033.

58. Based on savings observed at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue ($3.1M) is anticipated as a result of this proposal. Ex. A, p. 432.

59. The Hospital projects no incremental revenue for the first three fiscal years (FY 2016-2018) following the change in ownership, however operating gains of $1.5M, $3.1M and $3.2M, respectively, will be achieved from reductions in the cost of supplies and drugs and other operating expenses. Overall and with CON approval, the Hospital projects positive increasing gains from operations over the same time period.

TABLE 8
SAINT MARY'S HOSPITAL PROJECTED INCREMENTAL REVENUES AND EXPENSES (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	$0	$0	$0	$0
Total Operating Expenses	$0	($1,538)	($3,133)	($3,241)
Gain/Loss from Operations	**$0**	**$1,538**	**$3,133**	**$3,241**

TABLE 9
SAINT MARY'S HOSPITAL PROJECTED REVENUES AND EXPENSES WITH CON (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$301,416	$310,435	$319,530	$328,683
Total Operating Expenses	$297,061	$303,963	$311,078	$319,960
Gain/Loss from Operations	**$4,355**	**$6,472**	**$8,453**	**$8,723**

Ex. A, pp. 432-434; Testimony of Mr. Wable, Ex. N, p. 38.

60. The projected operational cost savings are summarized by expense category in the table below:

TABLE 10
SAINT MARY'S HOSPITAL PROJECTED OPERATING EXPENSE SAVINGS WITH CON (in thousands)

Expense Category	FY 2016	FY 2017	FY 2018	FY 2019
Supplies and Drugs	$0	($720)	($1,512)	($1,588)
Other Operating Expenses	0	($817)	($1,621)	($1,654)
Total Reductions	**$0**	**($1,538)**	**($3,133)**	**($3,241)**

Ex. A, p. 434;

61. THC's acquisitions of health systems and hospitals have yielded improved financial performances, cost savings and new capital investments:
    - Chelsea Community Hospital, Michigan - nearly a 40% increase in revenue between FY 2011 and FY 2016; approximately $67 million capital investment to construct a tower, including conversion to private acute beds; operating margin improved from 0.6% pre-merger to 4.4% in FY 2016;
    - Mercy Health, Hackley Campus, Michigan - annual aggregate savings of $1 million from enhanced revenue management and reduced supply and vendor costs; awarded 2016 America's Best Hospitals by Healthgrades; operating margin of 10% in FY 2015 compared to 1.0% in FY 2009, the first year after merging with THC;
    - St. Alphonsus Regional Medical Center, Idaho - $225 million in investments planned for campus relocation that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction; increase in Operating Cash Flow Margin to 16.3%, up from 6.4% in FY 2011; operating margin currently at 9.8%;
    - Loyola University Health System, Illinois - improved its first-year operational performance by $44.5 million across support functions, including insurance/risk

management, organizational integrity, supply chain, treasury, information services and revenue cycle; operating margin and operating cash flow margins have improved from -1.4% and 4.0% respectively to 1.2% and 6.5% in FY 2015;

- Catholic Health East, with facilities across 9 states - $285 million of synergies since the system level mergers occurred in May 2013, with more than $25 million in additional synergies planned through June 2016; operating expenses of $13.9 billion in FY 2015 with synergies savings of 1.8% of operating expenses; and
- St. Joseph Health, Inc., New York - $4 million in savings since merging with THC on July 2015 representing a synergies savings of 0.6% of operating expenses.
- St. Francis Hospital and Medical Center, Connecticut - has been a part of THC for over a quarter, but anticipated annualized savings of 7.6 million is expected to be realized representing 1% of operating expenses; a fixed pay interest rate swap was transferred to THC resulting in $44 million reduction in liability strengthening the balance sheet by increasing its unrestricted net assets.

Ex. E, pp. 872-873; Ex. G, p. 1018-1021.

62. There have been no changes in the price structure resulting from recent acquisitions other than St. Alphonsus Medical Center. Prices increased by approximately 12% as prior to the acquisition, prices had not increased for four years. Ex. G, p. 1021.

63. The Membership Transfer Agreement provides that within one year following closing, THC will develop a plan to address the Hospital's third party debt and to fully fund its pension plan obligations. Ex. A, pp. 114-115.

64. The Hospital's pension plan is underfunded by $75.9 million and its funding status was at 48% as of 9/30/2015. Currently, there are no plans to restructure the debt. A review to determine if an intercompany loan will be used to pay off or refinance the outstanding debt will be conducted post-closing. Ex. E, pp. 870-871; Ex. L, p. 1025; Testimony of Mr. Bittner, Ex. N, pp. 55-56.

65. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

66. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

67. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

68. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

69. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5))

70. The Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))

71. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

72. The Applicants provided historical utilization of Saint Mary's Health System services in the service area that supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

73. The Applicants have satisfactorily demonstrated that this proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

74. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))

75. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. (Conn. Gen. Stat. § 19a-639(a)(11))

76. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12))

DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

Saint Mary's Health System, Inc. ("SMHS") is a not-for-profit integrated Catholic health care delivery system serving the greater Waterbury area. *FF1.* SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliates. *FF2.* The Hospital, a 347-bed acute care general hospital, has served the greater Waterbury area since 1907, and is licensed as a Level II Trauma Center. It provides a full range of inpatient, outpatient and ancillary services to the 16 towns encompassing its primary service area. *FF3-4.*

In response to changes in health care delivery as well as federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to that of an accountable care organization focusing on population health management. SMHS determined it could best effectuate this and other goals of its strategic plan through a partnership. *FF5.* Additionally, the need for capital improvements to an aging infrastructure, the mandate to provide health services as reflected in the Community Health Needs Assessment, the requirement to meet the medicals records standard as a result of the Patient Protection and Affordable Care Act ("PPACA") and SMHS's debt obligations have made the need to partner with another health care provider essential in order to maintain the quality of care currently provided. *FF6.* SMHS, through its SMHS Board Taskforce ("Taskforce"), has been searching for a partner that would meet its philosophical principles and the resources to improve SMHS's financial strength. *FF7.* The Taskforce found Trinity Health Corporation ("THC") and the New England Regional Health Ministry ("TH-NE") to have a strategic plan similar to its own while sharing a common vision, philosophy, mission and compatible religious directives. *FF7-8.*

THC is a national Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs in 21 states. It is the sole shareholder of TH-NE. *FF11.* TH-NE is the parent company of health care facilities located in Connecticut, including Saint Francis Hospital in Hartford. *FF12.*

SMHS's Board of Directors approved a strategic alliance with TH-NE based on the findings and recommendation of the Taskforce. A membership agreement was signed on September 19, 2015. *FF9.* As a result of this agreement, the Applicants are requesting approval to transfer ownership of SMHS and its subsidiaries to TH-NE in order to become part of THC. *FF10.*

Following the completion of the transfer of ownership, it is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. *FF17.* TH-NE will be the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. *FF18.* The Applicants propose adding two members from the Hospital's community to the TH-NE Board of Directors who will be appointed by THC for three years. *FF19.* The governing board of the Hospital will remain unchanged other than the addition of the CEO of TH-NE. *FF19.* To ensure

quality concerns and the local health needs of the community are identified, local boards will have the ability to pass on relevant information to the regional governing boards through a representative. *FF20.*

TH-NE's organizational structure aims to create a system that meets the PPACA's objectives of improving population health and enhancing patient care experience while controlling costs. *FF13.* The Hospital will be able to leverage TH-NE's data and evidence-based national infrastructure to align and support clinicians in a Unified Clinician Organization ("UCO"). This will enable medical practitioners to work collaboratively throughout the THC-system to advance patient safety, best practices, quality and patient satisfaction. Hospitals participating in the TH-NE's UCO initiative have seen a decrease in sepsis mortality and pressure ulcer rates as well as an increase in patient satisfaction measures. *FF15.* Additionally, to address the increasing cost of hospital readmission, THC has developed a post-acute affiliated network resulting in a more accurate and efficient transition of patients from the hospital to the next level of care. *FF16.* The Hospital will be able to take advantage of THC's UCO and the associated best practices.

The Health Resources and Services Administration has designated Central Waterbury as a as a medically underserved area and medically underserved population. By affiliating with THC, the Hospital will gain the resources to strengthen health care in the region. *FF 25-26.* The Hospital's 2013 Community Health Needs Assessment ("CHNA") has identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement. *FF28.* The Hospital has also adopted the Connecticut Hospital Association's initiative to reduce instances of chronic conditions, specifically choosing to focus on asthma prevention. *FF29.* TH-NE has committed to integrating the health priorities identified by SMHS and the Hospital into its Community Health and Well-Being Strategy. *FF27.* The proposal will also benefit the local community by increasing access to resources of a large system, and its ability to develop more preventive and primary care services.

Following implementation of the proposal, an efficiency analysis will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize processes. However, neither the Hospital's clinical services nor its locations are expected to change as a result of this proposal. *FF21.* Additionally, the Hospital's Board would be required to approve a termination or a reduction of a service if it were to occur within three years following implementation. *FF22.* There are no proposed changes in services for the indigent or the Medicaid patients served by the Hospital. Furthermore, The Applicants do not anticipate any significant changes in the overall payer mix. *FF38-39.*

SMHS's charitable policies are consistent with both THC and TH-NE with no planned changes, thus ensuring that access to services for the Medicaid and indigent population continue. *FF41.* All charitable gifts to the Hospital will remain a part of the Hospital's Foundation and will continue to operate separately from the Hospital. All donations will continue to comply with existing donor restrictions. *FF42-43.* As a result, the integration of the Hospital with THC and TH-NE will allow the Hospital to maintain its commitment to the poor, the uninsured and underinsured as well as the Medicaid population.

There are no capital cost associated with the Transfer Agreement between the Applicants. *FF23.* Additionally, the proposal will enable the Hospital to make needed capital upgrades and investments. As a condition of THC's 2015 acquisition of Saint Francis *Care* and subsequent establishment of TH-NE, THC made a capital commitment of $275M to TH-NE. *FF48.* TH-NE is now proposing to commit at least $100M of that capital funding over the next five years to the Hospital. NE-RHM will contribute an additional $20M if the Hospital meets specific metrics in the 3rd and 4th year following the close of the transaction. *FF47.* Funding for the committed capital will be derived from cash and investments generated by the Hospital, financing obtained through the THC-system debt program and, if necessary, capital contributions from THC. *FF49.* The committed capital of $100M is a minimum that will not erode if further mergers were to occur. *FF52.*

The preliminary capital investment plan includes $40M in Hospital facility upgrades including the replacement of clinical equipment that has been delayed due to budgetary constraints. The remaining $60M is intended for the development of an electronic health records system, improving ambulatory care, converting to private patient rooms and developing a clinical network. *FF53.* In addition, the Hospital will be able to secure better long-term capital at favorable interest rates utilizing THC's strong credit ratings as well as develop a plan to adequately fund its pension obligations. *FF25, FF63.*

Cost savings will be achieved at the Hospital as a result of synergies expected to be realized as a result of becoming part of a larger system. Some synergies will be realized through a system of shared office services by THC members. The departments of revenue, treasury, human resources, supply chain management and information technology will be centralized. *FF55.* For use of these services, THC will impose a charge of 0.8% of NE-RHM's operating expenses, to be distributed among NE-RHM's member hospitals. Centralizing these departments will, however, likely result in net savings for TH-NE's members. *FF57.*

Based on observations at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue is anticipated as a result of this proposal. *FF58.* No incremental revenue for FY 2016 to 2018 is projected; however, operating gains of $1.5M, $3.1M, and $3.2M, respectively, are projected, in part, from reductions in the cost of supplies and drugs. In addition, the Hospital projects positive and increasing gains from operations following the transfer. *FF59.*

As a result of the potential for improved financial performance and new capital investments, the Applicants have demonstrated that the proposal is financially feasible and that the financial strength of the health care system will be improved by providing the Hospital with financial stability through improved access to capital and debt financing to preserve and enhance existing services.

The proposal will allow the Hospital to access TH-NE's system of best clinical practices, centralized office functions, and cost savings measures. Such benefits will enable the Hospital to invest in beneficial capital upgrades while still meeting its debt obligations and maintaining positive financial margins.

As a result of these combined factors, the Applicants have satisfactorily demonstrated that there is a clear public need for the proposal and that quality of care will improve through integration with a national system providing a variety of clinical and financial benefits. Thus, the Applicant has demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the transfer of ownership of SMHS and its controlled affiliates to Trinity Health – New England, Inc., a subsidiary of Trinity Health Corporation is hereby **Approved** under Conn. Gen. Stat. §19a-639 subject to the enumerated conditions (the "Conditions") set forth below

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether THC remains the parent company and sole shareholder of the Trinity Health–New England, Inc. ("TH-NE") OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, and the right to impose and collect a civil penalty under Conn. Gen. Stat. § l9a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the applicable website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§19a-613(b), 19a-639(a)(8) & (11); FF 21-22.*

2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall identify and provide the Certificates of Incorporation for the THC or TH-NE -affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. This entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-613(b), 19a-639(a)(8) & (11); FF 17-18*

3. TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:
    a. the Transfer Agreement, including any and all schedules and exhibits; and
    b. Bylaws or similar governance documents for the Hospital.

    TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If TH-NE redacts materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §19a-613(b); FF 9- 10, 19-20, 34.*

4. Following the completion of the Hospital's 2016 Community Health Needs Assessment (CHNA), TH-NE shall participate with the Hospital, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion. TH-NE and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. In the event that the Hospital has already substantially completed its 2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six months of the Closing Date. TH-NE shall publish the Community Health Needs Assessment and the Implementation Strategy on the website of the Hospital. Until such time as the CHNA and Implementation Strategy are submitted to OHCA, TH-NE shall continue to support and implement the Hospital's current CHNA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3) & (7); FF 27-30*

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

6. Until such time as the Services Plan is submitted, TH-NE shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date.

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[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF -21-22*

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

8. For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:

    a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

        1. the major cost savings achieved for each expense category for the semi-annual period; and

        2. the effect of these cost savings on the clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/350 (statement of operations) or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5);* FF *47-49, 53*

9. For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for the Hospital and TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio

6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Net Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5); FF 59-60*

10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

11. For three (3) years following the Closing Date, TH-NE shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of the Hospital within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the Hospital simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

13. TH-NE shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, TH-NE shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, TH-NE shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, TH-NE shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, TH-NE shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 29.*

14. For three (3) years following the Closing Date, Trinity shall allow for one (1) community representative to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting member under the Hospital's Board of Director Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of one unbiased persons who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 19-20*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

7-25-16
Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by D. SCOTT WORSWICK, EVP, GROWTH, STRATEGY + INNOVATION
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

July 22, 2016
Date

Duly Authorized Agent for
Trinity Health-New England

Signed by Christopher Dadlez, President + CEO
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

7/22/16
Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by Chad W. Wable, FACHE, President and Chief Executive Officer
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Saint Mary's Health System, Inc. and Trinity Health, Inc.

DN: 15-32045-CON

Hearing Date: May 9, 2016

Time: 3:00 PM

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Exhibit #	Description
1	Letter from Joan Hartley & Jeffery Berger
2	
3	
4	
5	

Intervenor Exhibit #	Description
1	
2	
3	
4	
5	
6	
7	

Informal Exhibit #	Description
1	
2	
3	
4	
5	
6	
7	

Applicant Late File #	Description	Due Date	Rec'd
1	Support Schedule showing how cash flow amounts were determined		
2			
3			
4			
5			
6			

Intervenor Late File #	Description	Due Date	Rec'd
1			
2			
3			
4			
5			
6			

Notes:

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Christopher DADDEZ	860-714-1915		Trinity Health-NE
James Richard O'Connell	719-332-0340		Trinity Health
David Bittner	860-714-1950		Trinity Health-NE
James Hawnis	860-714-4396		Trinity Health-NE
Adam Silverman	860-714-1966		↓

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Marcos M. McKinney	860 805-5971		Trinity Health NE
Jennifer J. Schneider	860 714-5360		Saint Francis Hospital - medical Gr
Thomas S. Marcian	860-331-2660		Hinckley Allen/Trinity Health NE
Robert J. Anthony	860-509-6517		Brown Rudnick/Saint Mary's
Michael G. Tabor	401-457-5239		Hinckley Allen/Trinity Health NE
Ralph Becker	203-709-5871		Saint Mary's
Chris Hayes	203-709-6294		Saint Mary's
Steven Schneider	203 709 3044		Saint Marys
Claudia Capone	860.276.7875		Trinity Health - NE
Robert J Mazurka	203-888-9181		St. Marys

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Chad Wolfe	203 709-3368		Saint Mary's Hospital
Liz Rotavera	860 714-5153		Saint Francis
Chris Hartley	860 714-5573		Saint Francis
PAT GERNER	860 794-1907		SAINT MARY'S
Joe Connolly	203 709 6369		SAINT Mary's

Applicant

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization

Public Official

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Ronald Pugliese	203 723.4411	203 729-4512	Naugatuck Economic Development
William Quinn, Waterbury Dir. of Health	203-574-6780	203-597-3481	City of Waterbury, Dept. of Health
Lynn Ward	203-757-0701	203-756-3507	Waterbury Regional Chamber
Neil O'leary			Mayor of Wtby

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Representing Organization
Nicholas J Coscia	Open Health Patient
Amit Mody MD	TMNE
MaryAnn Manley	St. Frances
Kevin Sullivan	Johnson Memorial Hospital
William [illegible]	[illegible]

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Stuart E. Rosenberg	Johnson Memorial Hospital
Joseph Carlson II	Public
Paul Kelly	Public
Kevin Reynolds	RSG
Hillary Glass	RSG
Phil Tartsinis	JMMC
Fiona Phelan	Saint Francis
Brenda Saxe	RSG
Harry Rosenthal	Y-NHHTS
S. Dolorosharn CSJ	SMH

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Patty Chant	Waterbury Hospital
Dick Pugh	ST Marys Hospital
CHRISTINA MASON	REPUBLICAN-AMERICAN NEWSPAPER
Nancy Rousseau	Trinity Health New England
CHRIS MILLER	SHARON HOSPITAL
Peter Cordeau	Sharon Hospital
Christian Bergeron	Sharon Hospital
Jennifer Clement	Saint Marys Hospital

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

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Nicholas J Cosca	OpenHealth Patient
Amit Mody MD	THNG
MaryAnn Manley	St. Frances
Kevin Sullivan	Johnson Memorial Hospital
William [illegible]	[illegible]

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
STUART E. ROSENBERG	JOHNSON MEMORIAL HOSPITAL
Joseph Carlson	Public
PAUL KELLY	Public
Kevin Reynolds	RSG
Hillary Glass	RSG
Phil Tartsinis	JMMC
Fiona Phelan	Saint Francis
BRENDA SISCO	RSG
Nancy Rosenthal	YNHHS
S. Doloreshann CSJ	SMH

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Patty Chant	Waterbury Hospital
Dick Pugh	ST Marys Hospital
CHRISTINA MASON	REPUBLICAN-AMERICAN NEWSPAPER
Nancy Rousseau	Trinity Health New England
CHRIS MILLER	SHARON HOSPITAL
Peter Cordeau	Sharon Hospital
Christian Bergeron	Sharon Hospital
Jennifer Clement	Saint Mary's Hospital

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

May 9, 2016

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Martone:

I am pleased to offer this testimony in support of the Certificate of Need application submitted by Trinity Health New England, Inc.'s Acquisition of Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.

I am supportive of this merger, in part, because I believe that Saint Mary's will be able to retain their local commitment, including their Catholic identity and mission, while being part of a more financially secure regional system. The $100 million commitment over five years will allow Saint Mary's to improve the delivery of quality care and help fulfill its community based mission. Patients will have greater access to medical expertise and shared resources.

Changes are occurring in our health care delivery system. I view the change contemplated in this transaction as a very positive step for Saint Mary's and the Greater Waterbury community. I thank you for your consideration of this proposal.

Very Truly Yours,

Joan Hartley
State Senator, 15th District

Jeffrey J. Berger
State Representative, 73rd District

Printed on recycled paper.

Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, August 19, 2016 9:20 AM
To: Greer, Leslie
Cc: Attorney Bob Anthony; Lubin-Szafranski, Janeanne; Joe Connolly (JConnolly@Stmh.org); Victoria Cipriano
Subject: Responses to 15-32045-CON Conditions
Attachments: Responses to 15-32045-CON Conditions - CAC - 8 18 2016.pdf

Hello Leslie,

Attached are Saint Mary's responses to conditions for CON Docket #: 15-32045-CON. A paper copy is being mailed as well. Please feel free to contact me with any questions you may have.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

Trinity Health
New England

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1000 Asylum Ave.
Hartford, CT 06106
860.714.6465
Fax: 860.714.8823

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

August 19, 2016

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue
MS#13HCA
P.O Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Greer:

In accordance with Items 1, 2, 3, 6 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

1. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the decision Date and publish this same information on the applicable website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.**

   In accordance with Condition 1 of the Order, Trinity Health – New England, Inc. is submitting schedules to OCHA setting forth Saint Mary's Hospitals inpatient bed allocation along with the location & hours of operation for all outpatient services by department (**See Attachment 1**). Currently, locations and hours of operation can be viewed on the Saint Mary's Hospital's website (www.stmh.org).

2. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE- affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. The entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral.**

   In accordance with Condition 2 of the Order, Trinity Health – New England, Inc. is submitting the Certificate of Incorporation for the TH-NE affiliated entities that shall directly own, operate and hold the hospital's license post-closing along with the document of existence under the laws of CT (**See Attachments 2**).

3. **TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:**
   a. **The Transfer Agreement, including any and all schedules and exhibits; and**
   b. **Bylaws or similar governance documents for the Hospital.**

   TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. 1-210. If TH-NE redacts materials in accordance with the previous sentence, the Applications shall provide a list to

OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral.

In accordance with Condition 3.a. of the Order, Trinity Health – New England, Inc. ("TH-NE") is submitting a copy of the Transfer Agreement, including any and all schedules and exhibits. Pursuant to Condition 3, TH-NE has redacted Schedule 6.15(a) from the copy of the Transfer Agreement submitted: Schedule 6.15(a) identifies correspondence from various state and federal agencies, contractors, and payors discussing matters relating to compliance with state and federal laws and reimbursement rules. The redacted information is exempt from disclosure because it is commercial or financial information given in confidence by the parties to each other even though such disclosure is not required by statute (see Conn. Gen. Stat. § 1-210 (5) (B)). Moreover, public disclosure of this information would unduly harm the parties and may create unwarranted unease among patients, potential patients, physicians, and other members of the community (**See Attachment 3**).

6. Until such time as the Services Plan is submitted, TH-NE shall provide OCHA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for patient population.

In accordance with Condition 6 of the Order, Trinity Health – New England, Inc. ("TH-NE") is notifying OCHA that there are no plans to reallocate inpatient beds or relocate any outpatient services for Saint Mary's Hospital at this time.

10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 1

IP Bed Allocation	
Department	Staffed Beds
Medical Acute (SH5)	21
Behavioral Health Services (OB1)	12
Telemetry	20
Orthopedics/Neuro (OB-4)	30
Medical Oncology (X-3)	26
General Surgery (OB-7)	23
Critical Care Unit	16
Cardiovascular Unit	8
Lobor/Delivery	23
Total Staffed Beds	179

OP Services by Department			
Department	**Location**	**Hours of Operation**	**Contact**
Behavioral Health Care Services	100 Visitation Plaza Waterbury, CT 06706	M, W & Th: 8A-8P T & F: 8A-4:30P	203-709-6201
Child Development Center	100 Visitation Plaza Waterbury, CT 06706	M-F: 6:30A - 5:45P	203-709-6385
Family Health Center	95 Scovill Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-3800
Naugatuck Valley Surgical Center	160 Robbins Street Waterbury, CT 06708	M-F: 6A -5P	203-755-6663
Cardiovascular Diagnostic Center	1320 West Main Street Waterbury, CT 06708	M-F: 6:30A - 3P	203-709-4506
Saint Mary's Blood Draw - East Main Street	1981 East Main Street Waterbury, CT 06705	M-Th: 7A-4:30P F: 7A-3P Sat: 7A -10:45A Hours for X-Ray M-Th: 8A-5P F: 8A-12P	203-709-6052
Saint Mary's Blood Draw- West Main Street	1312 West Main Street Waterbury, CT	M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P Hours for X-Ray M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P	203-709-4575
Saint Mary's Blood Draw- Scovill Street	133 Scovill Street Waterbury, CT 06706	M-F: 8:30A - 5P	203-709-3660
Saint Mary's Blood Draw-Southbury	303 Union Square, Southbury CT	M-F: 7A-4P Sat: 7A-11A	203-267-5611
Saint Mary's Blood Draw- Watertown	70 Hemingway Park Road Watertown, CT	M-F: 7:30A-4P	203-709-5931
Saint Mary's Urgent Care Center - Naugatuck	799 New Haven Road, Naugatuck CT	M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P	203-723-5636
Saint Mary's Urgent Care Center - Wolcott	503 Wolcott Road, Wolcott CT	M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P	203-879-7900

One Stop Testing (SMH)	56 Franklin Street Waterbury, CT 06706	M-F: 6A - 6P	203-709-6103
Saint Mary's Hospital Oncology Center	1075 Chase Parkway Waterbury, CT 06708	M-F: 7A-5P	203-591-3077
SMH Physical & Occupational Therapy - Waterbury	1981 East Main Street Waterbury, CT 06705	OT Hours M& W: 8:30A-7P T&Th: 7:30A-3P F: 8:30A - 2:30P PT Hours M-Th: 7A-7P F: 7A-5:30P	203-709-6232
SMH Physical Therapy & Low Vision Center - Naugatuck	799 New Haven Road, Naugatuck CT	M, T & F: 8A - 4:30P W & Th: 7A - 5:30P	203-720-1750
Saint Mary's Hospital Sleep Disorders Center - Wolcott	503 Wolcott Road, Wolcott CT	Friday: 9A - 12P Sleep Lab 9A-6P 7:30P - 6A	203-709-6243
Wound Center	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-3000
Saint Mary's OP Therapy	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-6216
OP Cardiac Rehab	56 Franklin Street Waterbury, CT 06706	M-F: 7A - 3:30P	203-709-6202
Saint Mary's OP Imaging	56 Franklin Street Waterbury, CT 06706	M-F: 6:30A - 8P Sat & Sun: 7A - 3:30P	203-709-6021
Same Day Surgery	56 Franklin Street Waterbury, CT 06706	M-F: 6A - 8P	203-709-6069
Nutrition Center	56 Franklin Street Waterbury, CT 06706	M: 11A - 5:30P T-F: 8:30A - 3:30P	203-709-3247
Saint Mary's Occupational Health & Diagnostic Center	1312 West Main Street Waterbury, CT	M-F: 8A - 4:30 P	203-709-3740
Saint Mary's Hospital Urgent Care - West Main Street	1312 West Main Street Waterbury, CT	M-F: 8A - 8P Sat: 9A - 5P Sun: 9A - 2P	203-709-4575
OP Pulmonolgy Clinic	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4P	203-709-6244
OP Cardiac Testing	56 Franklin Street Waterbury, CT 06706	M-F: 7A - 3:30P	203-709-6361

ATTACHMENT 2

AMENDED 11/17/2015

Amended and Restated Certificate of Incorporation of

Trinity Health – New England, Inc.

A Connecticut Nonstock Corporation

1. This Amended and Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

2. The text of the Amended and Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Trinity Health – New England, Inc. which was incorporated on July 31, 1997.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation as amended from time to time.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Trinity Health – New England, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Trinity Health Corporation, an Indiana nonprofit corporation, which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III
Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which,

in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Member and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

B. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

C. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

D. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

E. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

F. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations

exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

G. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

H. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) (or, if the Corporation is so classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV

Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Trinity Health Corporation, an Indiana nonprofit corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is c/o CT Corporation System, One Corporate Center, Hartford, CT 06103. The resident agent of the Corporation is CT Corporation System, One Corporate Center, Hartford, CT 06103. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Trinity Health Corporation, an Indiana nonprofit corporation is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member shall have exercised its reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member:

a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(b) Appoint and remove Directors of the Corporation, with or without cause, of if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(c) Ratify the appointment and removal of the Chair of the Board of Directors of the Corporation;

(d) Appoint and remove the President of the Corporation;

(e) Approve the strategic plan of the Corporation to the extent required pursuant to the System Authority Matrix, which shall be consistent with the strategic plan of Trinity Health;

(f) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health;

(g) Approve the operating and capital budgets of the Corporation;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries);

(j) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation;

(k) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation;

(l) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may be subject to approval by Catholic Health Ministries);

(m) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code;

(n) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by Trinity Health pursuant to this provision;

(o) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than to Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business; and

(p) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit corporations, as the case may be) by the state laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

ARTICLE VIII

Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a director, officer, employee, committee member, or agent of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for

such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Amended and Restated Certificate of Incorporation

This Amended and Restated Certificate of Incorporation is effective as of October 1, 2015.

Office of the Secretary of the State of Connecticut

I, the Connecticut Secretary of the State, and keeper of the seal thereof, DO HEREBY CERTIFY, that the certificate of incorporation of

TRINITY HEALTH - NEW ENGLAND, INC.

a domestic NONSTOCK corporation, was filed in this office on July 31, 1997, a certificate of dissolution has not been filed, the corporation has filed all annual reports, and so far as indicated by the records of this office such corporation is in existence.

Secretary of the State

Date Issued: August 10, 2016

Business ID: 0568101 Express Certificate Number: 2016249150001

Note: To verify this certificate, visit the web site http://www.concord.sots.ct.gov

ATTACHMENT 3

Execution Copy

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01**.

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01**.

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06**.

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06**.

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02**.

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"Certification of AFTAP" has the meaning set forth in **Section 6.22(c)**.

"**Church Plan**" has the meaning set forth in **Section 6.22(e).**

"**Closing**" has the meaning set forth in **Section 5.01**.

"**Closing Date**" has the meaning set forth in **Section 5.01**.

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01**.

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a).**

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04**.

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth **in Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"NE-RHM" has the meaning set forth in the preamble.

"NE-RHM Controlled Subsidiary" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"NE-RHM Providers" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"Trinity Health Controlled Subsidiary" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"Withdrawal Liability" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c),** and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12**.

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X**, **Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBITS AND DISCLOSURE SCHEDULES TO

MEMBERSHIP TRANSFER AGREEMENT

by and among

TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and
SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

EXHIBITS

Exhibit A .....Saint Mary's Exempt Subsidiaries

Exhibit B .....Saint Mary's Controlled Subsidiaries

Exhibit C .....Trinity Health System Authority Matrix

Exhibit D .....SMH Amended and Restated Certificate of Incorporation and Amended and Restated Bylaws

EXHIBIT A

SAINT MARY'S EXEMPT SUBSIDIARIES

Saint Mary's Hospital, Inc.

Saint Mary's Hospital Foundation, Inc.

EXHIBIT B

SAINT MARY'S CONTROLLED SUBSIDIARIES

Saint Mary's Hospital, Inc.

Saint Mary's Physician Partners, LLC

Saint Mary's Indemnity Company, LLC

Franklin Medical Group, P.C.

Diagnostic Imaging of Southbury, LLC

Naugatuck Valley MRI, LLC

EXHIBIT C

TRINITY HEALTH SYSTEM AUTHORITY MATRIX

See attached

June 25, 2015

TRINITY HEALTH
System Authority Matrix

This Authority Matrix summarizes a number of important activities that might be taken by an entity within the Trinity Health System and the corresponding actions or approvals that must be taken before proceeding with such activity. Many of these actions are delegations from the Board of Trinity Health to management, to Committees of the Board of Directors of Trinity Health and to governance of entities affiliated with Trinity Health. Trinity Health has adopted the following Operating Principles which apply to these delegations:

Unity: We act as a unified system, recognizing the interdependency of all its parts in fulfillment of its mission and vision while promoting the strength of our ministries serving our unique communities.

Excellence: We seek to continually innovate and improve our performance excellence and to add value by leveraging our skill and scale.

Simplicity and Clarity: Local, regional and system office leadership work in partnership to make decisions in a timely and collaborative manner that takes into account the variety of interests being affected.

Accountability: We are flexible in shaping roles, responsibilities and accountabilities at all leadership levels of the organization.

The Trinity Health Board retains control over its statutory obligations in carrying out the purposes of the corporation as the parent of a large Catholic health system. The Board is responsible for key strategic decisions and issues that will significantly impact the Trinity Health System. Delegations are established taking into account the balance between making efficient decisions close to the business activity and the need for the board and management to oversee areas of significant impact on the system as a whole in terms of Catholic Identity, strategic direction, risk and value.

The Board has adopted a process of Mission Discernment, which is intended to ensure that in the course of making major decisions, the Mission and Core Values are used as a measure to evaluate the effect of the proposed action.

This Authority Matrix is not intended to be an exclusive listing of the various actions reserved to Trinity Health or its affiliated entities. Trinity Health may clarify these delegations through policies. State law may confer additional rights or require additional actions. Those variations will be set forth in the governing documents of the entity and prevail over any conflicting authorities described in this System Authority Matrix. Different rights may also be set forth in the terms of joint venture organizing documents or other agreements. Decisions related to those joint venture entities should be made in accordance with the organizing documents; however, decisions which exceed financial thresholds or which may, in management's judgment, affect the reputation or identity of the Trinity Health System are required to be reviewed by Trinity Health management, regardless of the minority position held by the CHE Trinity affiliate in the joint venture.

Entities:

Catholic Health Ministries or CHM means the public juridic person that sponsors the Trinity Health system and exercises all canonical responsibilities related to its operations, subject to certain rights retained by sponsoring congregations or public juridic persons until such time as the stable patrimony (property) under the control of those sponsoring congregations or public juridic persons is alienated (transferred) to CHM.

Trinity Health means Trinity Health Corporation, an Indiana nonprofit corporation, which is the parent of the Trinity Health System.

Trinity Health System means Trinity Health, together with its subsidiaries and affiliates.

Ministry or Ministries means any or all RHMs, NHMs, and MHMs.

Mission Health Ministry or MHM means a first tier subsidiary of Trinity Health that maintains a governing body and which has oversight of non-institutional health operations and/or grant making. A list of MHMs is set forth on Exhibit A to this Matrix.

National Health Ministry or NHM means a first tier (direct) subsidiary that maintains a governing body that has day to day management oversight of a business line throughout the Trinity Health System. A list of NHMs is set forth on Exhibit A to this Matrix.

Regional Health Ministries or RHM means a first tier (direct) subsidiary, affiliate or operating division of Trinity Health that maintains a governing body that has day to day management oversight of a designated portion of the Trinity Health System within a geographical market. A list of RHMs is set forth Exhibit A to this Matrix.

Group 1 RHM means an RHM which had a minimum total operating revenue of $300 million in the previous fiscal year or an RHM that has been selected by management for inclusion in Group 1 RHMs based on operational objectives.

Group 2 RHM means an RHM which is not a Group 1 RHM.

Second Tier Subsidiaries means subsidiaries and affiliates of Ministries.

Actions:

Approve means to have ultimate authority over an action. Approval includes the authority to adopt, accept, modify, disapprove or send back for further consideration an action recommended or approved by another entity in the Trinity Health System. Some actions required approval at more than one level. Final approval authority is exercised by the highest level independently of any recommendation or participation actions. If more than one entity has Approval authority, the matter may be initiated and approved by the highest level of Approval authority when permitted by law.

Participate means a timely, meaningful, collaborative and consultative process among interested parties to inform the decision under consideration.

Ratify means to confirm and adopt the act of another even if it was not approved beforehand. It also means final decision making authority, but without the power to initiate or change a recommendation.

Recommend means to review and present a matter for approval by another entity in the Trinity Health System. Recommending authority does not limit the right of the approving entity to initiate an action without a recommendation.

Other:

Governing documents are documents which establish and describe an entity, including the purposes, the powers reserved to the members or shareholders, and which set forth the rights of partners or joint owners relative to each other. Governing documents include documents

filed with the state (such as articles or certificates of incorporation), bylaws (whether a corporation or an unincorporated division which has its own governing body), operating agreements and partnership agreements.

Key Bylaws Provisions are variations from the standard Governing Documents that concern any of the following: (a) the Ministry name and corporate purposes; (b) the Mission, Core Values and Catholic Identity of the Ministry and powers exercisable by CHM; (c) the identity of, reserved powers exercisable by and other matters pertaining to Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Ministry Board of Directors. All other variations are not Key Bylaw Provisions.

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
I	**Statements of Identity**					
I a	Trinity Health System Mission Statement	-	-	-		Approve
1 b	Trinity Health System Core Values	-	-	-		Approve
II	**Governing Documents**					
II a	Articles and Bylaws of Trinity Health Corporation	-	-	Recommend	Approve and Recommend	Ratify
II b	Governing Documents of Ministries consistent with standard form approved by Trinity Health Board	-	Approve and Recommend	Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel)	Approval of Governing Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions	-

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
II c	Governing Documents of Second Tier Subsidiary which operates licensed healthcare facilities consistent with standard form approved by Trinity Health Board	-	Approve and Recommend	Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel)	Approval of Governance Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions	-
II d	Governing Documents of Second Tier Subsidiary	Recommend	Approve	Approve		
III	**Appointments and Removals**					
III a	Appointment or removal of CHM Members (which comprise the Trinity Health Board of Directors)					Approve
III b	Appointment or removal of Trinity Health Board Chair				Approve	Ratify
III c	Appointment or removal Ministry Boards of Directors		Recommend	Recommend	Approve (Executive and Governance Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
III d	Appointment or removal of Ministry Board Chairs		Approve		Ratify (Executive and Governance Committee)	
III e	Appointment or removal of Second Tier Subsidiaries Governing Body	Recommend	Approve			
III f	Appointment or removal of Trinity Health CEO				Approve	Ratify
III g	Appointment or removal of Ministry CEOs	Participate	Recommend	Approve		
III h	Appointment or removal of Second Tier Subsidiaries CEOs	Approve				
IV	**Strategy**					
IV a	Trinity Health System Strategic Plans			Recommend	Approve	
IV b	Group I RHM and NHM Strategic Plans	Recommend	Approve	Approve		
IV c	Group 2 RHM and MHM Strategic Plans	Recommend	Approve	Participate		

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V	**Finance Matters**					
V a	Group I RHM and NHM Capital Acquisitions and Dispositions	Recommend	Approve up to 2% of net assets with a maximum of $5million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	Approval as required by Canon Law
V b	Group II RHM and MHM Capital Acquisitions and Dispositions	Recommend	Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	Approval as required by Canon Law
V c	Additional Debt and System Five Year Plan of Finance			Recommends	Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V d	System Operating and Capital Budget			Recommend	Approve (upon recommendation by Stewardship Committee)	
V e	RHM Operating and Capital Budget	Recommend	Approve	Approve		
V f	Second Tier Operating and Capital Budget	Recommend	Approve			
V g	Contracts (including leases) in which the Trinity Health is the financially obligated			Approve up to $25 million	Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee)	
V h	Contracts (including leases) in which a Group I RHM or a NHM is financially obligated	Recommend	Approve up to 2% of net assets with a maximum of $5million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V i	Contracts (including leases) in which a Group II RHM or MHM is financially obligated	Recommend	Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	
V j	Auditor Selection (Trinity Health System and separate audits)			Recommend	Approve (upon recommendation by the Audit Committee)	
V k	Annual Trinity Health System Audit			Recommend	Approve (upon recommendation by the Audit Committee)	
VI	**New Organizations and Major Transactions**					
VI a	Major change affecting Trinity Health (merger, consolidation, creation, transfer, sale of substantially all assets)			Recommend	Approve	Approve

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VI b	Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) not related to an Trinity Health System reorganization	Recommend	Recommend (Approve if required by State law)	Recommend	Approve	Approve as related to Sponsorship obligations
VI c	Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) related to a Trinity Health System reorganization	Recommend	Recommend (Approve if required by State law)	Recommend	Stewardship Committee Approve	Approve as related to Sponsorship obligations
VI d	Major change affecting Second Tier Subsidiaries (merger, consolidation, creation, transfer, sale of all assets)	Recommend	Approve	Approve		Approve as related to Sponsorship obligations
VI e	Internal operational reorganization affecting tier structure	Participate	Recommend	Approve		

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VI f	Formation or acquisition of an entity in which Trinity Health will be the sole parent			Recommend	Approve	Approve as related to Sponsorship obligations
VI g	Joint venture or other enterprise affecting ownership of a Group I RHM or NHM	Recommend	Approve	Recommend	Approve	Approve as related to Sponsorship obligations
VI h	Joint venture or other enterprise affecting ownership of a Group II RHM or MHM	Recommend	Approve	Recommend	Approval by Stewardship Committee	Approve as related to Sponsorship obligations
VII	**People Centered Care**					
VII a	Trinity Health System Wide Quality and Safety Standards	Participates		Recommends	Approves (upon recommendation of the People Centered Care Committee	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VII b	RHM Quality and Safety Standards (consistent with Trinity Health System Quality Standards)	Recommends	Approves			
VII c	Annual review of Trinity Health System Quality and Safety			Recommends	People Centered Care Committee Approves, Board Receives Report	
VII d	Annual review of RHM Quality and Safety	Recommends	Approves	Receive Report		

EXIHIBIT A

MINISTRIES
Based on the FY 2014 Income Statement

REGIONAL HEALTH MINISTRIES (RHMs) – GROUP I

Holy Cross Health (Maryland)
Holy Cross Hospital (Florida)
Loyola University Health System (Illinois)
Mercy Health (Michigan)
Mercy Health Services – Iowa (Iowa)
Mercy Health System of Southeastern Pennsylvania (Pennsylvania)
Mount Carmel Health System (Ohio)
Our Lady of Lourdes Health Care Services (New Jersey)
Saint Agnes Medical Center (California)
Saint Alphonsus Health System (Idaho)
Saint Joseph Mercy Health System (Michigan)
Saint Joseph Regional Medical Center (Indiana)
Sisters of Providence Health System (Massachusetts)
St. Mary Medical Center (Pennsylvania)
St. Mary's Health Care System (Georgia)
St. Peter's Health Partners (New York)

REGIONAL HEALTH MINISTRIES (RHMs) – GROUP II

Mercy Health System of Chicago (Illinois)
Saint James Mercy Health System (New York)
Saint Michael's Medical Center (New Jersey)
St. Francis Hospital (Delaware)
St. Francis Medical Center (New Jersey)

NATIONAL HEALTH MINISTRIES (NHMs)

Trinity Home Health Services (multi-state)
Trinity Senior Living Communities (multi-state)
Trinity PACE

MISSION HEALTH MINISTRIES (MHMs)

Allegany Franciscan Ministries (Florida)
Global Health Ministry (Pennsylvania)
Mercy Medical (Alabama)
Pittsburgh Mercy Health System (Pennsylvania)
Saint Joseph's Health System (Georgia)

Approved by Trinity Health Executive and Governance Committee 6/18/14, effective 7/1/14; revised and approved by the Trinity Health Executive and Governance Committee on January 27, 2015; revised and approved by the Trinity Health Board of Directors on February 25, 2015; revised and approved by the Trinity Health Executive and Governance Committee on April 9, 2015; approved by Catholic Health Ministries on June 25, 2015.

EXHIBIT D

SAINT MARY'S HOSPITAL, INC. AMENDED AND RESTATED CERTIFICATE OF INCORPORATION AND AMENDED AND RESTATED BYLAWS

[SEE ATTACHED]

Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Saint Mary's Hospital, Inc.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III

Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on

behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV
Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable

law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

ARTICLE VIII

Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a

member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

BYLAWS

OF

SAINT MARY'S HOSPITAL, INC.

A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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ARTICLE I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

(i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or

(ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

Article II. PURPOSES

Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the Ethical and Religious Directives for Catholic Health Care Services as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE III. MEMBER

Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

Section 3.02 Member Authority

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

Section 3.03 Reserved Powers of Trinity Health

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

Section 3.04 Meetings of the Member

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

ARTICLE IV. BOARD OF DIRECTORS

Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the

Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation (who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

Section 4.03 Term

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

Section 4.04 Annual Meeting of the Board of Directors

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

Section 4.05 Regular Meetings and Notice

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

Section 4.06 Special Meetings and Notice

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

Section 4.07 Waiver of Notice

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

Section 4.08 Quorum and Valid Director Action

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

Section 4.09 Written Consents

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

Section 4.10 Communication Equipment

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 4.11 Resignation

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

Section 4.12 Removal

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

Section 4.13 Periodic Performance Review

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

ARTICLE V. MEDICAL/DENTAL STAFF

Section 5.01 Medical/Dental Staff Bylaws

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

Section 5.02 Medical/Dental Staff of Operating Units

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

ARTICLE VI. COMMITTEES

Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective

committees through the next annual meeting or until their successors are appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

Section 6.04 Quorum, Meetings, Rules and Procedures

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

Section 6.05 Committee Composition

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

ARTICLE VII. OFFICERS

Section 7.01 Officers

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time. Officers shall hold their respective offices until their successors are chosen and qualified.

Section 7.02 Appointment and Election of Officers

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The

Chair shall serve a term of one (1) year and may be elected for a total of three (3) consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

Section 7.03 Vacancies

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

Section 7.04 Chair

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

Section 7.05 President

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

Section 7.06 Secretary

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

Section 7.07 Treasurer

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such

delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

ARTICLE VIII. INDEMNIFICATION AND STANDARD OF CARE

Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 8.04 Justifiable Reliance

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 8.05 Consideration of Factors

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 8.06 Presumption

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

Section 8.07 Personal Liability of Directors

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

ARTICLE X. OPERATING UNITS

Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

Article XI. MISCELLANEOUS

Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time

required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

Section 11.03 Confidentiality

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

Section 11.04 Conflict of Interest

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

ARTICLE XII. AMENDMENT AND REVIEW

Section 12.01 Amendment

These Bylaws may be amended only in accordance with Article III of these Bylaws.

Section 12.02Periodic Review

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

DISCLOSURE SCHEDULE

This Disclosure Schedule (this "Disclosure Schedule") is being delivered pursuant to the terms of that certain Membership Transfer Agreement (the "Agreement"), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation ("Trinity Health"), Saint Francis Care, Inc., a Connecticut nonstock corporation ("NE-RHM"), and Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital, Inc. ("SMH"), both Connecticut nonstock corporations (collectively, "Saint Mary's"). The substitution of NE-RHM for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A .....Knowledge of Saint Mary's

Schedule 1B .....Knowledge of NE-RHM

Schedule 1C .....Knowledge of Trinity Health

Schedule 2.01..... Board of Directors and Officers of SMH

Schedule 3.02.....Board of Directors and Officers of RHM

Schedule 6.04.....Conflicts/Consents

Schedule 6.05.....Organizational Chart

Schedule 6.08.....Absence of Certain Changes, Events and Conditions

Schedule 6.09(a) .....Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries

Schedule 6.09(c) .....Material Contracts

Schedule 6.10.....Permitted Encumbrances

Schedule 6.12(a) .....Owned Real Property/Encumbrances

Schedule 6.12(b) .....Leased Real Property

Schedule 6.14(a) .....Legal Proceedings

Schedule 6.14(b) .....Governmental Orders, Judgments, Penalties, Awards

Schedule 6.15(a) .....Compliance With Laws/Permits

Schedule 6.16(a) .....Government Program Survey Reports

Schedule 6.16(b) .....Reimbursement Claims

Schedule 6.16(d) .....Accreditation Survey Report and Deficiency List

Schedule 6.19.....Breach Notifications

Schedule 6.22(a) .....Employee Benefit Plans

Schedule 6.22(c) .....Employee Pension Benefit Plans

Schedule 6.22(d) .....Multiemployer Plans

Schedule 6.22(e) .....Church Plans

Schedule 6.22(f).....Employee Welfare Benefit Plans

Schedule 6.22(g) .....Agreements with Employees, Etc.

Schedule 6.22(h) .....Prohibited Transactions

Schedule 6.22(k) .....Nonqualified Deferred Compensation Plans

Schedule 6.23.....Collective Bargaining Agreements; Threats of Strike, Slowdown, etc.

Schedule 6.24 .....Tax Returns, Tax Payments
Schedule 6.25 .....Insurance Policies
Schedule 7.04 .....Conflicts/Consents
Schedule 7.08(a) .....Compliance with Laws
Schedule 7.09(a) .....Government Program Survey Reports
Schedule 7.09(b) .....Reimbursement Claims
Schedule 7.12 .....Breach Notification
Schedule 8.08(a) .....Owned Real Property

DISCLOSURE SCHEDULE

This Disclosure Schedule (this **"Disclosure Schedule"**) is being delivered pursuant to the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of _____, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Saint Francis Care, Inc., a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**). The substitution of **NE-RHM** for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to **NE-RHM and** Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A _____	Knowledge of Saint Mary's
Schedule 1B _____	Knowledge of NE-RHM
Schedule 1C _____	Knowledge of Trinity Health
Schedule 3.02 _____	Board of Directors of NE-RHM - Saint Mary's Members
Schedule 6.04 _____	Conflicts/Consents
Schedule 6.05 _____	Organizational Chart
Schedule 6.07 _____	Undisclosed Liabilities
Schedule 6.08 _____	Absence of Certain Changes, Events, Conditions
Schedule 6.09 _____	Material Contracts
Schedule 6.09(c) _____	Material Contracts - Validity
Schedule 6.10 _____	Permitted Encumbrances
Schedule 6.11 _____	Condition and Sufficiency of the Saint Mary's Assets
Schedule 6.12(a) _____	Owned Real Property
Schedule 6.12(b) _____	Leased Real Property
Schedule 6.14(a) _____	Legal Proceedings
Schedule 6.14(b) _____	Governmental Orders
Schedule 6.15(a) _____	Compliance With Laws
Schedule 6.16(a) _____	Medicare - Plans of Correction
Schedule 6.16(b) _____	Medicare - Claims
Schedule 6.16(d) _____	Medicare - Accreditation Surveys/Deficiency List
Schedule 6.19 _____	HIPAA - Breach Notifications
Schedule 6.20 _____	Affiliate Transactions
Schedule 6.21(e) _____	Environmental
Schedule 6.22(a) _____	Employee Benefit Plans
Schedule 6.22(b) _____	Benefit Plans - Compliance
Schedule 6.22(c) _____	Employee Pension Benefit Plan Liability
Schedule 6.22(d) _____	Multiemployer Plan Liability
Schedule 6.22(e) _____	Church Plans
Schedule 6.22(f) _____	Employee Welfare Benefit Plans
Schedule 6.22(g) _____	Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans
Schedule 6.23 _____	Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

Schedule 1A

Knowledge of Saint Mary's

1. Chad Wable, CEO
2. Ralph Becker, CFO
3. Chip Flynn, COO
4. Steve Schneider, MD, Chief Medical Officer, President of Franklin Medical Group

Schedule 1B

Knowledge of NE-RHM

1. Christopher M. Dadlez, President and CEO
2. John Rodis, Executive Vice President and COO
3. David Bittner, Senior Vice President of Finance, CFO
4. Janeanne C. Lubin-Szafranski, Vice President and General Counsel
5. Jennifer S. Schneider, Vice President of Finance

Schedule 1C

Knowledge of Trinity Health

1. James R. O'Connell, Executive Vice President
2. Paul Neumann, Executive Vice President and General Counsel
3. Benjamin Carter, Executive Vice President and CFO
4. Michael Holper, Senior Vice President

Schedule 2.01

SMH Board Members

The initial members of the SMH Board will be identified by the Parties prior to the Closing Date

Schedule 3.02

Board of Directors of NE-RHM - Saint Mary's Members

To be identified by Parties prior to the Closing Date

Schedule 6.04

Conflicts/Consents

(a) None.

(b)

OHCA CON Order, Docket No. 08-31202. Condition 2(b) to the Order provides that the Heart Center's CON authorization will become invalid and therefore null and void if, "any changes in the ownership or control of one or both of the legal entities, [Saint Mary's Hospital or the Waterbury Hospital]" occur. Saint Mary's and Waterbury Hospital are in the process of filing a CON Modification requesting that OHCA vacate Condition 2(b).

(c)(i)

(1) Waterbury Hospital pursuant to Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999, the Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003, and the bylaws of both Harold Leever and the Heart Center.

(2) Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

(3) Connecticut Department of Social Services Health Care Financing - Provider Enrollment Agreement, dated 3/12/09, between CT DSS and Saint Mary's Hospital. Re-enrollment requires notification

(4) Craneware License and Service Agreement, dated 4/29/13, between Craneware plc and Saint Mary's Hospital. Assignment, which includes change of ownership, requires consent.

(5) McKesson Premier Member Letter of Participation, dated 12/16/13, between McKesson and Saint Mary's Health System, Inc. Notice required on change of ownership.

(6) The following consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Saint Mary's Hospital or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby:

a. Roman Catholic Archdiocese of Hartford
b. Holy See, Roman Catholic Church
c. State of Connecticut Office of Healthcare Access
d. Office of the Attorney General of the State of Connecticut
e. Federal Trade Commission

(7) Consent may be required with respect to Diagnostic Imaging of Southbury, LLC

(c)(ii) None.

(c)(iii) None.

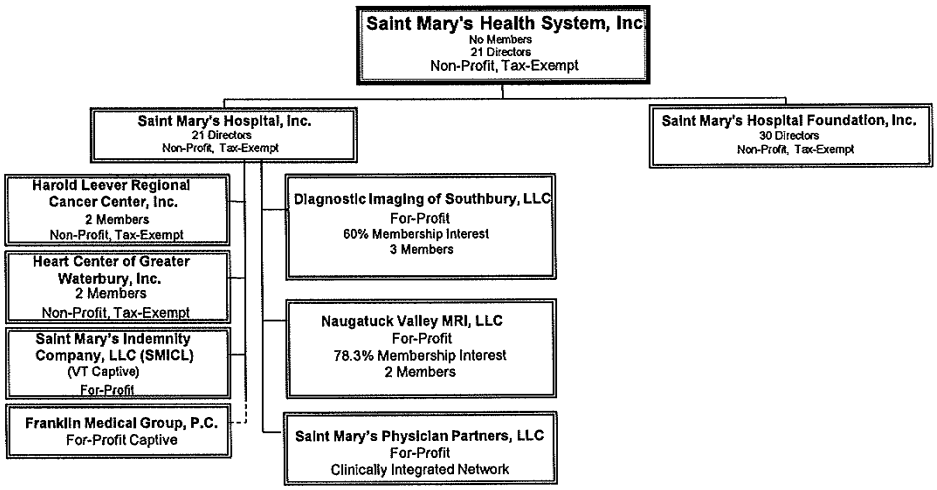
(c)(iv) None.

(c)(v)

1. Master Service Agreement, dated 1/5/09, between Connecticut Children's Medical Center and Saint Mary's Hospital, Inc.

Schedule 6.05

Organizational Chart



August 2015

Schedule 6.07

Undisclosed Liabilities

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000

2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.

3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.

4. Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

   Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

Schedule 6.08

Absence of Certain Changes, Events, Conditions

6.08(a):

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.08(b):

Saint Mary's is in the process of converting Franklin Medical Group to a Medical Foundation.

6.08(c): None

6.08(d): None

6.08(e): None

6.08(f): None

6.08(g): None

6.08(h): None

6.08(i): None

6.08(j):

An electrical transformer failed in July 2015. Replacement of the transformer itself and associated labor are expected to be greater than $100,000. Incident has not been submitted to

insurance. Awaiting final invoices from contractor.

6.08(k):

The receivable for $315k as of June 30, 2015 for CVS retail pharmacy will be written off by end of year. The retail pharmacy program started in April FY15. The program is being discontinued. Approximately $165k was accrued for expenses associated with these revenues. Those will also be released to income. The net impact to the income statement will be approximately $150k.

SMH capitalized $904k worth of fixed asset additions in the month of July. Cath Lab equipment ($190k) and build out of West Main Urgent Care ($151k) were included.

6.08(l): None

6.08(m): None

6.08(n): None

6.08(o): None

6.08(p): None

6.08(q): None

6.08(r): None

Schedule 6.09

Material Contracts

(i) Each Contract involving aggregate consideration in excess of $100,000

See attached.

(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000

1. Asset Purchase Agreement by and among Saint Mary's Hospital, Inc. and Joseph Bowen, M.D., dated June 1, 2014

2. Asset Purchase Agreement by and among Franklin Medical Group, P.C. and Digestive Disease Center of CT, LLC, dated May 23, 2014

(iii) All Contracts with any Governmental Authority

1. Student Educational Affiliation Agreement between Waterbury Department of Education and Saint Mary's Hospital, July 27, 2007

2. Provider Enrollment Agreement between Connecticut Department of Social Services and Saint Mary's Hospital, dated March 3, 2009

3. Board of Trustees of Community-Technical Colleges on behalf of Northwestern Connecticut Community College, dated January 3, 2011

4. Student Educational Affiliation Agreement between University of Connecticut, School of Social Work and Saint Mary's Hospital, dated January 17, 2011

5. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Franklin Medical Group, dated October 14, 2011

6. Educational Agreement between the University of Connecticut School of Medicine and Saint Mary's Hospital, dated December 20, 2011

7. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated November 7, 2012

8. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated November 21, 2012

9. In-State Student Affiliation Agreement between University of Connecticut, Department of Allied Health Sciences and Saint Mary's Hospital, dated January 1, 2013

10. In-State Student Affiliation Agreement between University of Connecticut School of Nursing and Saint Mary's Hospital, dated January 2, 2013

11. Child Day Care License between State of Connecticut Department of Public Health and Saint

Mary's Hospital, dated March 20, 2013

12. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 22, 2013

13. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated May 5, 2013

14. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated June 19, 2013

15. Purchase of Service Contract between Department of Public Health and Saint Mary's Hospital, dated July 1, 2013

16. Student Education Affiliation Agreement between Western Connecticut State University and Saint Mary's Hospital, dated September 7, 2013

17. Contract between Board of Regents for Higher Education on behalf of Gateway Community College and Saint Mary's Hospital, dated October 22, 2013

18. Student Education Affiliation Agreement between Central Connecticut State University and Saint Mary's Hospital, dated October 28, 2013

19. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 4, 2014

20. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated February 6, 2015

21. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, Inc., dated February 20, 2015

22. In-State Student Educational Training Affiliation Agreement between University of Connecticut, Department of Kinesiology and Saint Mary's Hospital, dated May 28, 2015

23. Agreement between City of Waterbury and Saint Mary's Hospital Child Development Center (pending City signature)

(iv) **Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement**

1. Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999.

2. Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003

3. Operating Agreement of Southbury Diagnostic Imaging Center, LLC, dated October 7, 1998

4. Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

5. Affiliation Agreement among The Waterbury Hospital and St. Mary's Hospital, dated December 22, 2003

(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand

1. Cardiac Anesthesia Services Agreement between the Heart Center of Greater Waterbury, Inc. and Saint Mary's Hospital Inc., dated October 2007
2. Operating Agreement of Saint Mary's Physician Partners, LLC, dated June 27, 2014
3. Operating Agreement of Saint Mary's Indemnity Company, LLC, dated July 1, 2009
4. Services Agreement by and between the Harold Leever Regional Cancer Center, Inc., and Saint Mary's Hospital, dated October 9, 2002
5. Emergency Department Services Agreement by and between Saint Mary's Hospital and Franklin Medical Group, P.C., dated May 1, 2003
6. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003
7. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003
8. Cardiology Services Agreement by and between Waterbury Heart Center, Inc., St. Mary's Hospital, and Waterbury Hospital, and Cardiology Associates of Waterbury, P.C., dated November 1, 2004

(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party

None.

(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000
2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.
3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.
4. Master Lease Agreement by and between Saint Mary's Hospital and De Lage Landen Financial Services, Inc., dated December 28, 2009, as amended

SAINT MARY'S HOSPITAL CONTRACTS

MASTER COMMERCIAL CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1002C	Saint Mary's Hospital	Geonetric Technology
1001.1007E	Saint Mary's Hospital	McKesson Corporation
1001.1008E	Saint Mary's Hospital	McKesson Corporation
1001.1009E	Saint Mary's Hospital	McKesson Corporation
1001.1012C	Saint Mary's Hospital	McKesson Corporation
1001.1016C	Saint Mary's Hospital	Medtronic, Inc.
1001.1017C	Saint Mary's Hospital	Medtronic, Inc.
1001.1019C	Saint Mary's Hospital	Quinnipiac University
1001.1024E	Saint Mary's Hospital	Nuance Powerscribe
1001.1025E	Saint Mary's Hospital	Naugatuck Valley Community College
1001.1050C	Saint Mary's Hospital	RelayHealth
1001.1053C	Saint Mary's Hospital	RelayHealth
1001.1054C	Saint Mary's Hospital	Connecticut Hospital Association
1001.1060C	Saint Mary's Hospital	Roche Diagnostics Corporation
1001.1063E	Saint Mary's Hospital	Nuance Communications, Inc.
1001.1064E	Saint Mary's Hospital	McKesson Corporation
1001.1065C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1071C	Saint Mary's Hospital	Leidos Health LLC
1001.1083C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1085C	Saint Mary's Hospital	JVK Operations
1001.1092C	Saint Mary's Hospital	WB Mason
1001.1099C	Saint Mary's Physician Partners, LLC	Naugatuck Valley Women's Health Specialists, PC
1001.1100E	Saint Mary's Hospital	Wellsoft Corporation
1001.1119C	Saint Mary's Hospital	Healthstream, Inc.
1001.1120C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1121C	Saint Mary's Hospital	Allscripts Healthcare, LLC
1001.1160C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.1161C	Saint Mary's Hospital	Spirit of Women Health Network
1001.1165C	Saint Mary's Hospital	Kronos
1001.1168C	Saint Mary's Hospital	Siemens Healthcare Diagnostics Inc.
1001.1171C	Saint Mary's Hospital	Grainger Industrial Supply
1001.1173C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.1177C	Saint Mary's Hospital	Truven Health
1001.1178C	Saint Mary's Hospital	Spendadvisor

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1185C	Saint Mary's Hospital	Universal Background Screening
1001.1187C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1188C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1189C	Saint Mary's Hospital	Intuitive Surgical, Inc.
1001.1191C	Saint Mary's Hospital	Beckman Coulter
1001.1193C	Saint Mary's Hospital	Draeger Medical, Inc.
1001.1194C	Saint Mary's Hospital	Carl Zeiss Incorporated
1001.1204C	Saint Mary's Hospital	Cross Country Staffing
1001.1221C	Saint Mary's Hospital	Bard Peripheral Vascular, Inc.
1001.1225C	Saint Mary's Hospital	NVMRI
1001.1226C	Saint Mary's Hospital	Edwards Lifesciences LLC
1001.1231C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1237C	Saint Mary's Hospital	Covidien Sales, LLC
1001.1248C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1250C	Saint Mary's Hospital	St. Jude Medical
1001.1274C	Saint Mary's Hospital	PMA Management Corp. of New England
1001.1275C	Saint Mary's Hospital	Neuro Enterprises, LLC
1001.1286C	Saint Mary's Hospital	Baxter Healthcare Corporation
1001.1294C	Saint Mary's Hospital	Covidien
1001.190C	Saint Mary's Hospital	St Jude Medical US Division
1001.204E	Saint Mary's Hospital	Stericycle, Inc.
1001.210C	Saint Mary's Hospital	Craneware, Inc.
1001.216C	Saint Mary's Hospital	University of Connecticut School of Medicine
1001.219C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.228C	Saint Mary's Hospital	Naugatuck Valley Lawn Maintenance, Inc.
1001.235E	Saint Mary's Hospital	School Readiness Grant Program
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.287C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.304E	Saint Mary's Hospital	Stryker
1001.332C	Saint Mary's Hospital	Heart Center of Greater Waterbury, Inc.
1001.354E	Saint Mary's Hospital	Sodexho Operations, LLC
1001.367E	Saint Mary's Hospital	Yale University School of Medicine
1001.393C	Saint Mary's Hospital	3M Health Care Service Center
1001.411C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.418E	Saint Mary's Hospital	TPC Associates, Inc.
1001.420C	Saint Mary's Hospital	Western Connecticut State University
1001.427C	Saint Mary's Hospital	Sodexho Operations, LLC
1001.430C	Saint Mary's Hospital	Yale University School of Medicine

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.433C	Saint Mary's Hospital	Yale University School of Medicine
1001.444C	Saint Mary's Hospital	Northwestern Connecticut Community College
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.468C	Saint Mary's Hospital	University of Connecticut, Department of Allied Health Sciences
1001.469C	Saint Mary's Hospital	University of Connecticut School of Nursing
1001.474C	Saint Mary's Hospital	Haemonetics Corporation
1001.47C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.482C	Saint Mary's Hospital	Department of Public Health
1001.489C	Saint Mary's Hospital	Gateway Community College
1001.490C	Saint Mary's Hospital & Health System	Santa Buckley Energy, Inc.
1001.495E	Saint Mary's Hospital	GE Healthcare
1001.519C	Saint Mary's Hospital	University of Connecticut School of Social Work
1001.521C	Saint Mary's Hospital	Department of Social Services
1001.525C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.527E	Saint Mary's Hospital	Connecticut Light and Power Company
1001.541C	Saint Mary's Hospital	Waterbury Department of Education
1001.545C	Saint Mary's Hospital	Healthstream, Inc.
1001.54C	Saint Mary's Hospital	3M Health Care Service Center
1001.590C	Saint Mary's Hospital	bioMerieux, Inc.
1001.592C	Saint Mary's Hospital	American National Red Cross
1001.603C	Saint Mary's Hospital	Unitex Textile Rental Services
1001.608C	Saint Mary's Hospital	City-Wide Delivery Service, Inc.
1001.632C	Saint Mary's Hospital	McKesson Health Solutions, LLC
1001.633E	Saint Mary's Hospital	Otis Elevator Company
1001.653C	Saint Mary's Hospital	Siemens Industry, Inc.
1001.668C	Saint Mary's Hospital	Yale University School of Medicine
1001.676E	Saint Mary's Hospital	SkillSurvey
1001.679C	Saint Mary's Hospital	3M Health Care Service Center
1001.681C	Heart Center of Greater Waterbury	University of Connecticut Health Center Department of Finance
1001.682C	Saint Mary's Hospital	Med3000, Inc.
1001.688C	Saint Mary's Hospital	Yale University School of Medicine
1001.691C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.694C	Saint Mary's Hospital	Healthstream, Inc.
1001.749C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.750C	Saint Mary's Hospital	Connecticut Light and Power Company

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.768C	Saint Mary's Health System	Axiom Group, LLC
1001.783C	Saint Mary's Hospital	Best Practices, Inc.
1001.785C	Saint Mary's Hospital	MedAssets Net Revenue Systems, LLC
1001.786C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.787E	Saint Mary's Hospital	GE Medical Systems
1001.788C	Saint Mary's Hospital	Financial Health Strategies, Inc.
1001.811C	Saint Mary's Hospital	Department of Public Health
1001.814C	Saint Mary's Hospital	Executive Health Resources, Inc. (E.H.R.)
1001.820E	Saint Mary's Hospital	Dell
1001.8221C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.822C	Saint Mary's Hospital	Healthstream, Inc.
1001.825E	Saint Mary's Hospital	Diagnostic Equipment Service Corporation (DESCO)
1001.829C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.840C	Saint Mary's Hospital	University of Connecticut School of Allied Health
1001.852C	Saint Mary's Hospital	Bay State Anesthesia
1001.853C	Saint Mary's Hospital	Department of Public Health
1001.858C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.860C	Saint Mary's Hospital	Syntrac Cardinal Health
1001.861C	Saint Mary's Hospital	Sunquest Information Systems, Inc.
1001.866C	Saint Mary's Health System	VPNE Parking Solutions, LLC
1001.882C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.883C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.884C	Saint Mary's Hospital	Olympus America, Inc.
1001.886C	Saint Mary's Hospital	Telephone Nurse Triage - Kanagaratnam Jegathesan, MD
1001.890E	Saint Mary's Hospital	Corepoint
1001.891C	Saint Mary's Hospital	Advantage RN
1001.944C	Saint Mary's Hospital	RelayHealth
1001.950C	Saint Mary's Hospital	Xtend Healthcare, LLC
1001.962C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.979C	Saint Mary's Hospital	Yale University School of Medicine
1001.997C	Saint Mary's Health System, Inc.	McKesson Corporation
1002.1048C	Franklin Medical Group, P.C.	Nuance Communications, Inc.
1002.1090C	Franklin Medical Group, P.C.	Digestive Disease Center of CT, LLC
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1002.448C	Franklin Medical Group, P.C.	Department of Public Health
1002.530C	Franklin Medical Group, P.C.	Napiello, Virginia APRN
1002.572E	Franklin Medical Group, P.C.	Microsoft Licensing, GP

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.888E	Franklin Medical Group, P.C.	Phoenix Internal Medicine Associates, LLC
1002.958C	Franklin Medical Group, P.C.	VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc.
1002.959C	Franklin Medical Group, P.C.	Thames Records Management
1002.967C	Franklin Medical Group, P.C.	City-Wide Delivery Service, Inc.
1002.974C	Franklin Medical Group, P.C.	Intuitive Surgical, Inc.
1010.946C	Saint Mary's Hospital	Healthstream, Inc.
1010.966C	Saint Mary's Hospital	Healogics Wound Care & Hyperbaric Services, Inc.
1010.968C	Saint Mary's Hospital	Commerce Bank
1010.978C	Saint Mary's Hospital	Central Connecticut State University
1010.984E	Saint Mary's Hospital	Alliance Healthcare Services
1010.985C	Saint Mary's Hospital	Jackson & Coker Permanent, LLC

NON-PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.445C	Saint Mary's Hospital, Inc.	Union Square Southbury, LLC (Landlord)
2005.445C	Saint Mary's Hospital, Inc.	Associated Physicians of Southbury, P.C. (Subtenant)
2005.762C	Saint Mary's Hospital, Inc.	146 Highland Associates, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc.	1981 East Main Street, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc. (Sublandlord)	Inwelligent Healthcare, Inc. (Subtenant)
2007.104C	Saint Mary's Hospital, Inc.	Scovill Commons Partners, LLC (Landlord)
2007.1186E	Saint Mary's Hospital, Inc.	Subway Real Estate Corp. (Tenant)
2007.1227C	Saint Mary's Hospital, Inc.	Northwest CT Public Safety Communications Center Inc. (Tenant)
2007.245C	Saint Mary's Hospital Corporation	Spectrum Square, LLC (Landlord)
2007.273E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.285E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.330E	Saint Mary's Hospital, Inc.	500 Chase Parkway Condominium Association, Inc. (Landlord)
2007.345C	Saint Mary's Hospital, Inc.	Paolo Mappelli, M.D. (Landlord)
2007.509E	Saint Mary's Hospital Corporation	Scovill Commons Partners, LLC (Landlord)
2007.760C	Saint Mary's Hospital	JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord)
2007.761C	Saint Mary's Hospital	Park West, LLC (Landlord)

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2007.765E APPRAISAL/OPINION - NOT REVIEWED	N/A	N/A
2013.1129C	Franklin Medical Group, P.C.	1177, LLC (Landlord)

PROVIDER CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1072C	Saint Mary's Hospital	Singanamala, Santhi MD
1001.1082C	Saint Mary's Hospital	Waterbury Pulmonary Associates, LLC
1001.1105C	Saint Mary's Hospital	Brittny Williams Howell, MD
1001.110C	Saint Mary's Hospital	Martinucci, Erica MD
1001.1176C	Saint Mary's Physician Partners, LLC	
1001.1216C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.1298C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.323E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.342C	Saint Mary's Hospital	Consultants In Pathology, PC
1001.37C	Saint Mary's Hospital	Rho, Mira MD
1001.39C	Saint Mary's Hospital	Roer, David MD
1001.407C	Saint Mary's Hospital	Neurosurgery Orthopaedics & Spine Specialists PC
1001.783E	Saint Mary's Hospital	EmCare, Inc. AND EmCare, Inc.
1001.480C	Saint Mary's Hospital	Milford Anesthesia Associates, LLC
1001.543E	Saint Mary's Hospital	Koteles, Alicia MD
1001.547C	Saint Mary's Hospital	Raissi, Sina MD
1001.570C	Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership)	SurgiCenter Anesthesiologists, PC
1001.580C	Saint Mary's Hospital	Mayo Medical Laboratories
1001.593C	Saint Mary's Hospital	Zarif, Abdul MD
1001.68C	Saint Mary's Hospital	Zarif, Abdulmasih MD
1001.764C	Saint Mary's Hospital	Naugatuck Valley Women's Health Specialists, PC
1001.988E	Saint Mary's Hospital	Wellmore Behavioral Health
1002.1020C	Franklin Medical Group, P.C.	Monzurul Chowdhury, MD
1002.1022C	Franklin Medical Group, P.C.	Farah Chinwalla, DO
1002.1031C	Franklin Medical Group, P.C.	Bechoi Saleib, MD
1002.1037C	Franklin Medical Group, P.C.	Anna Freitag, MD
1002.1041C	Franklin Medical Group, P.C.	Lakshmi Polisetty, MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.1051C	Franklin Medical Group, P.C.	Frank Longo, MD
1002.1067C	Franklin Medical Group, P.C.	Ken Matsuo
1002.1069C	Franklin Medical Group, P.C.	Joseph Bowen, MD
1002.1101C	Franklin Medical Group, P.C.	Marano, Albert
1002.1102C	Franklin Medical Group, P.C.	Lyall, Bhupinder
1002.1103C	Franklin Medical Group, P.C.	Feinberg, Michael
1002.1104C	Franklin Medical Group, P.C.	Kraus, Mark, MD
1002.1107C	Franklin Medical Group, P.C.	Anupama Paranandi, MD Infectious Disease
1002.1109C	Franklin Medical Group, P.C.	Sallie Carrington, DO
1002.1110C	Franklin Medical Group, P.C.	Preissler, MD Paul
1002.1112C	Franklin Medical Group, P.C.	Garsten, MD Joel
1002.1113C	Franklin Medical Group, P.C.	Burlison, MD Kathleen
1002.1117C	Franklin Medical Group, P.C.	Cohen, Matthew, MD
1002.113C	Franklin Medical Group, P.C.	Palesty, J Alexander MD
1002.116C	Franklin Medical Group, P.C.	Wetmore, Robert S MD, PC
1002.117C	Franklin Medical Group, P.C.	Sieling, Beth Ann MD
1002.118C	Franklin Medical Group, P.C.	Sookhan, Nicole MD
1002.11C	Franklin Medical Group, P.C.	Rosenhein, Brian DO
1002.1208C	Franklin Medical Group, P.C.	Giacomazzi, Peter, MD
1002.120C	Franklin Medical Group, P.C.	Galal, Magdy MD
1002.1238C	Franklin Medical Group, P.C.	Shetty, MD Shohan
1002.1240C	Franklin Medical Group, P.C.	Albin, MD Dmitry
1002.1242C	Franklin Medical Group, P.C.	Neamtu, MD Andreea
1002.1268C	Franklin Medical Group, P.C.	Gork MD, Ahmet
1002.1269C	Franklin Medical Group, P.C.	Khan MD, Tasneem
1002.1270C	Franklin Medical Group, P.C.	Salerno MD, John
1002.1271C	Franklin Medical Group, P.C.	Polokoff MD, Ellen
1002.1272C	Franklin Medical Group, P.C.	Leal MD, Daniel
1002.1277C	Franklin Medical Group, P.C.	Medrano MD, Consuelito
1002.1278C	Franklin Medical Group, P.C.	Esemuede MD, Iyare
1002.1281C	Franklin Medical Group, P.C.	Thiruvengadam MD, Sudha
1002.12C	Franklin Medical Group, P.C.	Sheikh, Abdul Majeed MD
1002.1300C	Franklin Medical Group, P.C.	Carolyn O'Connor, MD
1002.1303C	Franklin Medical Group, P.C.	Greco, Thomas MD
1002.1304C	Franklin Medical Group, P.C.	Ann Marie Conti-Kelly, MD
1002.15C	Franklin Medical Group, P.C.	Te, Victorio Go MD
1002.18E	Franklin Medical Group, P.C.	Simms, Michael F MD
1002.20C	Franklin Medical Group, P.C.	Imam, Azhar MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.22C	Franklin Medical Group, P.C.	Nawaz, Shah MD
1002.23C	Franklin Medical Group, P.C.	Alston, Shawnette MD
1002.25C	Franklin Medical Group, P.C.	Beri, Rohit MD
1002.26C	Franklin Medical Group, P.C.	Bogursky, Sondra MD
1002.299C	Franklin Medical Group, P.C.	Anthony, J Robert MD
1002.29C	Franklin Medical Group, P.C.	Colodner, Gregory MD
1002.34C	Franklin Medical Group, P.C.	Newell, Rebecca O MD
1002.36C	Franklin Medical Group, P.C.	Ouellette, Jason MD
1002.379C	Franklin Medical Group, P.C.	Chere, Mitch MD
1002.3C	Franklin Medical Group, P.C.	Ramos, Rey MD
1002.41C	Franklin Medical Group, P.C.	Talwalkar, Jaideep MD
1002.42C	Franklin Medical Group, P.C.	Vaezy, Ali MD
1002.432C	Franklin Medical Group, P.C.	Ndiaye, Mouhamed A MD
1002.457C	Franklin Medical Group, P.C.	Gega, Arjet MD
1002.486C	Franklin Medical Group, P.C.	Chien, Peter MD
1002.493C	Franklin Medical Group, P.C.	Kelly, Paul MD
1002.501C	Franklin Medical Group, P.C.	Zhang, He MD
1002.503C	Franklin Medical Group, P.C.	Baba, Carolina Borz MD
1002.508C	Franklin Medical Group, P.C.	Rubenstein, Stephen MD
1002.513C	Franklin Medical Group, P.C.	Rovetto, Allyson MD
1002.515C	Franklin Medical Group, P.C.	Brenes, Laura C MD
1002.516C	Franklin Medical Group, P.C.	Zlotoff, Ronald A MD
1002.517C	Franklin Medical Group, P.C.	Singanamala, Swathi MD
1002.528C	Franklin Medical Group, P.C.	D'Souza, Bernard MD
1002.548E	Franklin Medical Group, P.C.	University of Connecticut Health Center
1002.55C	Franklin Medical Group, P.C.	Almeida, Carlos MD
1002.569C	Franklin Medical Group, P.C.	Richi, Maysoun MD
1002.56C	Franklin Medical Group, P.C.	Alvarez, Alexander J MD
1002.58C	Franklin Medical Group, P.C.	Testa, John MD
1002.59C	Franklin Medical Group, P.C.	Uberti, James G MD
1002.614C	Franklin Medical Group, P.C.	Richi, Aziz MD
1002.617C	Franklin Medical Group, P.C.	Toon, Claire DDS
1002.655C	Franklin Medical Group, P.C.	Quinn, Edmund
1002.685C	Franklin Medical Group, P.C.	Karen Kennedy
1002.69C	Franklin Medical Group, P.C.	Cardiology Associates of Waterbury, PC
1002.756C	Franklin Medical Group, P.C.	Zefirova, Julia MD
1002.758C	Franklin Medical Group, P.C.	Cumberland, Melisha MD
1002.763C	Franklin Medical Group, P.C.	Sanders, Tiffany MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.817C	Franklin Medical Group, P.C.	Mario Perez
1002.827E	Franklin Medical Group, P.C.	Seli, Meltem MD
1002.848C	Franklin Medical Group, P.C.	Albajrami, Oltjon MD
1002.879C	Franklin Medical Group, P.C.	Ranjan, Saurabh MD
1002.887C	Franklin Medical Group, P.C.	El-Hennawy, Magdy Sayed MD
1002.8C	Franklin Medical Group, P.C.	Hamill, Chalmers M MD
1002.915C	Franklin Medical Group, P.C.	Philip R. Corvo, MD
1002.93C	Franklin Medical Group, P.C.	Naugatuck Valley OBGYN PC
1002.943C	Franklin Medical Group, P.C.	Maria Dawe, MD
1002.961C	Franklin Medical Group, P.C.	Macaron, Shady Hafez MD
1002.972C	Franklin Medical Group, P.C.	Naugatuck Valley Women's Health Specialists, PC
1002.987C	Franklin Medical Group, P.C.	Jennyffer Peralta, MD
1002.993C	Franklin Medical Group, P.C.	Aditi Mukherji, MD
1002.994C	Franklin Medical Group, P.C.	Richard Putnam, DMD
1002.995C	Franklin Medical Group, P.C.	Rebecca Scandrett, MD
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center

PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.364C	Saint Mary's Hospital	Saint Mary's Hospital
2007.1285C	Saint Mary's Hospital	LJL Properties, LLC
2007.296C	Saint Mary's Hospital	West Main Medical, LLC, a Connecticut limited liability company, as Landlord
2008.534C	Primary Care Partners, P.C.	Greater Waterbury Primary Care Associates, P.C., as Tenant

Schedule 6.09(c)

Material Contracts - Validity

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

Schedule 6.10

Permitted Encumbrances

See attached lien report, dated September 14, 2015, prepared by CT Lien Solutions for all entities in Saint Mary's Health System

Blanket liens in favor of the master trustee (#0001772303) and in favor of Baytree National Bank & Trust Company (#0002913889) will be released prior to closing

Schedule 6.11

Condition and Sufficiency of the Saint Mary's Assets

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

Schedule 6.12(a)

Owned Real Property

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

2. Parcel Two

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

3. Parcel Three

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

4. Parcel Four

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

5. <u>Parcel Five</u>

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

6. Parcel Six

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

7. Parcel Seven

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

8. Parcel Eight

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

9. Parcel Nine

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

10. Parcel Ten

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

11. Parcel Eleven

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

12. Parcel Twelve

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

13. Parcel Thirteen

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

14. Parcel Fourteen

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

15. Parcel Fifteen

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

16. Parcel Sixteen

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

17. Parcel Seventeen

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

18. Parcel Eighteen

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

NORTHERLY:	79 feet on East Main Street
EASTERLY:	136 feet on Second Piece;
SOUTHERLY:	on land now or formerly of The Church of the Immaculate Conception; and
WESTERLY:	136 feet on land now or formerly of The Church of the Immaculate Conception.

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

NORTHERLY:	28.00 feet, more or less, by East Main Street;
EASTERLY:	130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street;
SOUTHERLY:	20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and
WESTERLY:	136.00 feet by land of Philip Avery.

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

NORTHEASTERLY:	19.86 feet by East Main Street;
SOUTHEASTERLY:	136.00 feet by land now or formerly of Philip Veillette, et al;
NORTHEASTERLY:	again 99.25 feet by land now or formerly of Philip Veillette, et
SOUTHEASTERLY:	al; again 43 feet, more or less, by Baldwin Street, fka Mill
SOUTHEASTERLY:	Street; again
SOUTHWESTERLY:	by Baldwin Street, fka Mill Street;
NORTHWESTERLY:	251.25 feet by land now or formerly of the Church of the Immaculate Conception; 136.68 feet by land now or formerly of the Church of the Immaculate Conception.

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

Schedule 6.12(b)

Leased Real Property

1. Lease Agreement by and between 1981 East Main Street LLC and Saint Mary's Hospital, Inc. dated May 18, 2010 for property located at 1981 East Main Street, Waterbury, Connecticut.

2. Agreement of Lease, by and between Crosspointe Plaza LLC and Saint Mary's Hospital dated August 18, 2000 for property known as the off-site Naugatuck Walk–In at Crosspointe Plaza Unit Numbers A1 and A2, as amended by the First Amendment to Lease dated April 27, 2009.

3. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, First Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

4. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, Lower Level, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

5. Lease by and between The Slocum Corporation and Saint Mary's Hospital Corporation dated October 1, 2002 for property at the medical building located at Scovill Street and Cole Street.

6. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital, Inc. dated November 18, 2005 for property located at 95 Scovill Street, Pavilion B, Second Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated September 10, 2007.

7. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital Corporation dated March 1, 2006 for property located at 95 Scovill Street, Pavilion B, Third Floor, Waterbury, Connecticut.

8. Lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006 for property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, as modified by the Lease Modification Agreement, dated January 1, 2009.

9. Commercial Lease by and between Metcalf Realty LLC and Saint Mary's Hospital, Inc. dated September 1, 2007 for property known as Bullet Hill Park and located at 33 Bullet Hill Road, Building A – Main Level, Southbury, Connecticut.

10. Lease by and between West Main Medical LLC and Saint Mary's Hospital, Inc. dated March 2004 for property located at 1312 West Main Street, Waterbury, Connecticut, as amended by the Amendment to Lease dated October 2004.

11. Indenture of Lease by and between Park West LLC and Saint Mary's Hospital dated March 21, 2002 for property located at 1320 West Main Street and Park Road in Waterbury, Connecticut, as amended by (i) the Amendment to Lease Agreement dated October 23, 2003 and (ii) the Second Amendment to Lease dated November 2004.

12. Lease by and between Spectrum Square LLC and Saint Mary's Hospital Corporation, Inc. dated February 24, 2004 for property located at 503 Wolcott Road, Second Floor, Wolcott, Connecticut, as amended by the Amended and Restated Lease dated April 1, 2006.

13. Lease by and between Southbury Properties Limited Partnership and Scovill Medical Group, P.C. dated February 1, 1997 for property known as the Union Square Shopping Center and located at Main Street South and Peter Road, Southbury, Connecticut, as modified by (i) the Sublease Agreement, dated May 1, 1998, (ii) the Amendment of Lease dated July 1999, (iii) the Amendment of Lease dated August 1, 1999, (iv) the Assignment of Leases and Security Deposits dated February 25, 2004 and (v) the Assignment, Third Amendment and Extension of Lease dated May 2006.

14. Commercial Lease Agreement by and between 146 Highland Associates LLC and Saint Mary's Hospital, Inc. dated January 2011 for property located at 146 Highland Avenue, Waterbury, Connecticut.

15. Lease Agreement by and between The Harold Leever Regional Cancer Center, Inc. and Saint Mary's Hospital, Inc., dated June 1, 2014 for property located at 1075 Chase Parkway, Waterbury, Connecticut.

16. Office Sublease Agreement by and between D'Vine Medical Spa LLC and Franklin Medical Group, P.C., dated September 30, 2013, for property located at 590 Middlebury Road, Middlebury, Connecticut.

17. Office Sublease Agreement by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

18. Office Lease Agreement by and between Prospect Medical, LLC, and Saint Mary's Hospital, Inc., dated December 1, 2010, for property located at 166 Waterbury Road, Suite 202, Prospect, Connecticut.

19. Lease Agreement by and between French's Mill Associates II LLP and Naugatuck Valley Surgical Center Limited Partnership, dated December 1, 2009, for property located at 160 Robbins Street, Waterbury, Connecticut

20. Indenture of Lease by and between Medical Investors L.L.C. and Saint Mary's Hospital, Inc., dated December 2, 2010 for property located at 70 Heminway Park Road, Watertown, Connecticut.

21. Lease Agreement by and between 1177, LLC and Franklin Medical Group, Inc., dated August 26, 2014, for property located at 1177 New Haven Road, Naugatuck, Connecticut.

22. Sublease Agreement by and between Westside Medical Group, P.C., and Franklin Medical Group, P.C., dated September 1, 2014, for property located at 714 Chase Parkway, Waterbury, Connecticut.

23. Lease by and between Edward I. Bushka and Margarita Bushka and Franklin Medical Group, dated July 22, 2014, for property located at 60 Westwood Avenue, Waterbury, Connecticut.

24. Lease by and between LJL Property, LLC, and Saint Mary's Hospital, Inc., dated June 17, 2015, for property located at 3528 East Main, Waterbury, Connecticut.

25. Lease by and between Bradley Medical Building Associates, L.L.C., and Franklin Medical Group, P.C., dated July 1, 2014, for property located at 55 Meriden Avenue, Suite 3C, Southington, Connecticut.

26. Lease by and between RPG Highland LLC and Saint Mary's Hospital, Inc., dated July 13, 2015, for property located at 1154 Highland Avenue, Cheshire, Connecticut.

27. Lease Agreement by and between Arev Three Limited Partnership and Ellen G. Polokoff, M.D., LLC, dated May 10, 2007, for property located at 900 Main Street South, Southbury, Connecticut, as amended by a First Amendment, dated September 30, 2009, a Second Amendment, dated November 30, 2011, and a Third Amendment, dated December 30, 2013. Ellen G. Polokoff M.D., LLC, assigned the lease to Franklin Medical Group, P.C., effective April 20, 2015.

28. Agreement of Lease by and between 385 Union Square Realty LLC and Comprehensive Health Care, LLC, dated October 2005, for property located at 385 Main Street South, Southbury, Connecticut, as amended by First Amendment, dated January 2009, and Second Amendment, dated April 2014. Agreement of Lease was assigned to Franklin Medical Group, P.C., effective July 31, 2015.

29. Office Lease, as amended, by and between Prospect Office LLC and Waterbury Primary Care Associates, P.C., dated December 2, 2004, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut. Office Lease assigned to Prospect Medical LLC, effective January 2008.

30. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

31. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Franklin Medical Group, P.C., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

Schedule 6.14(a)

Legal Proceedings

Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.

In each of the *Doe* matters, the plaintiffs allege that they were victims of sexual molestation perpetrated by the same priest while patients at Saint Mary's Hospital in the 1970s. The George Doe case was mediated before Judge Zemetis on June 30, 2015. The case was settled for $500,000 and will be paid in full by Travelers Insurance Company. Because the plaintiff was in bankruptcy, the settlement is subject to bankruptcy court approval. The remaining three *Doe* matters are being scheduled for mediation. Because Travelers filed a reservation of rights in 2008, Travelers has not affirmed coverage of the remaining three cases but is expected to provide coverage in full.

Schedule 6.14(b)

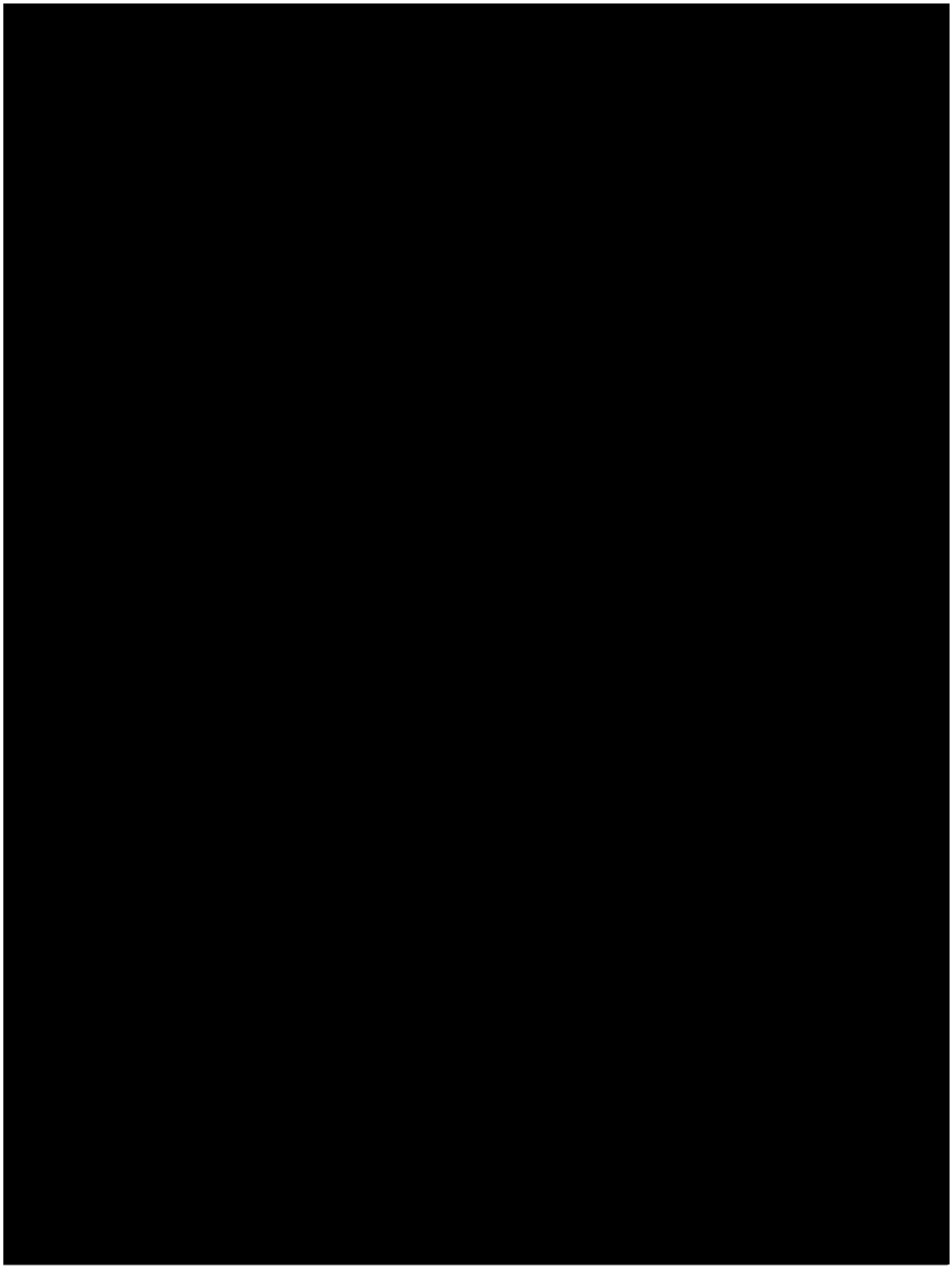
Governmental Orders

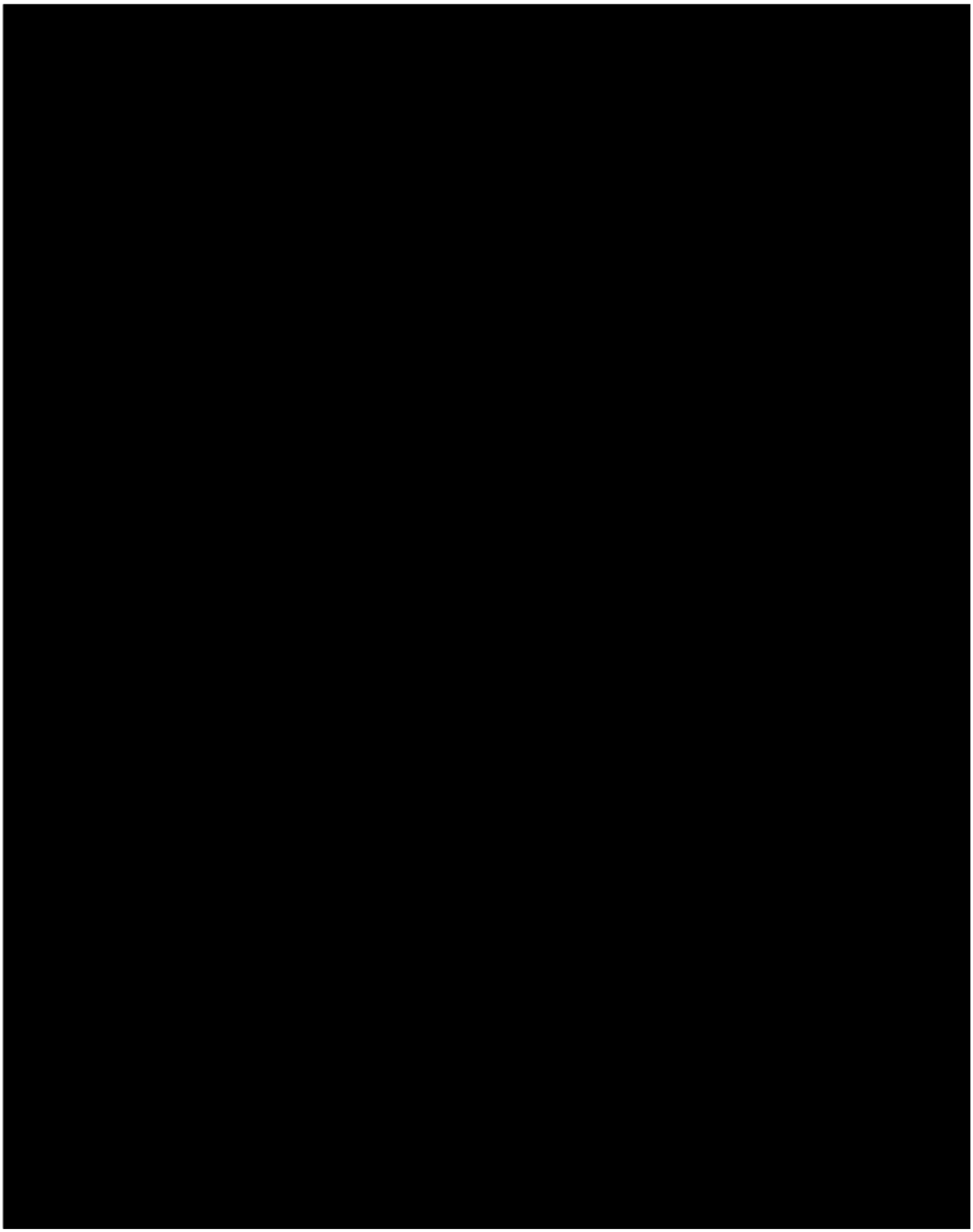
None.

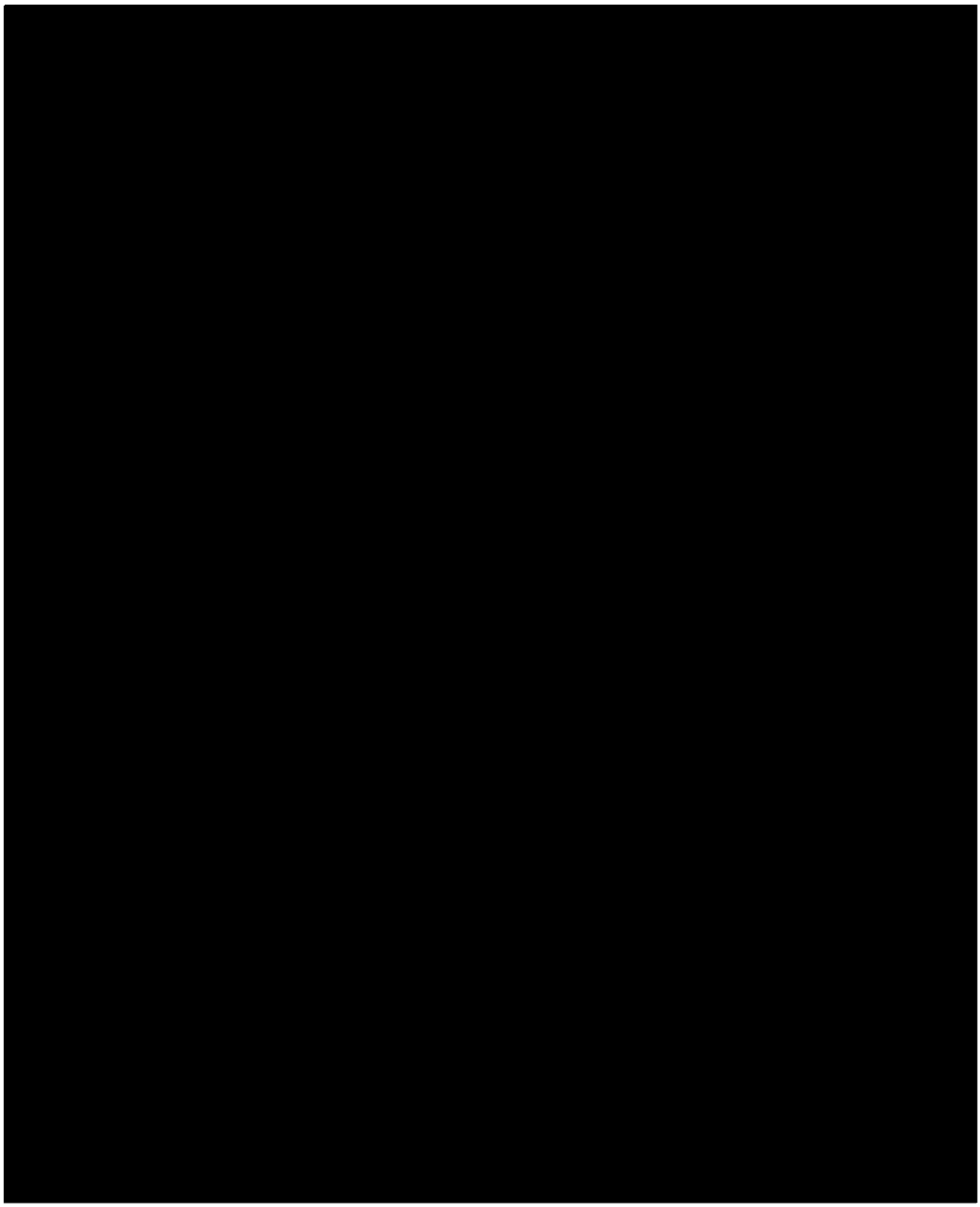
Schedule 6.15(a)

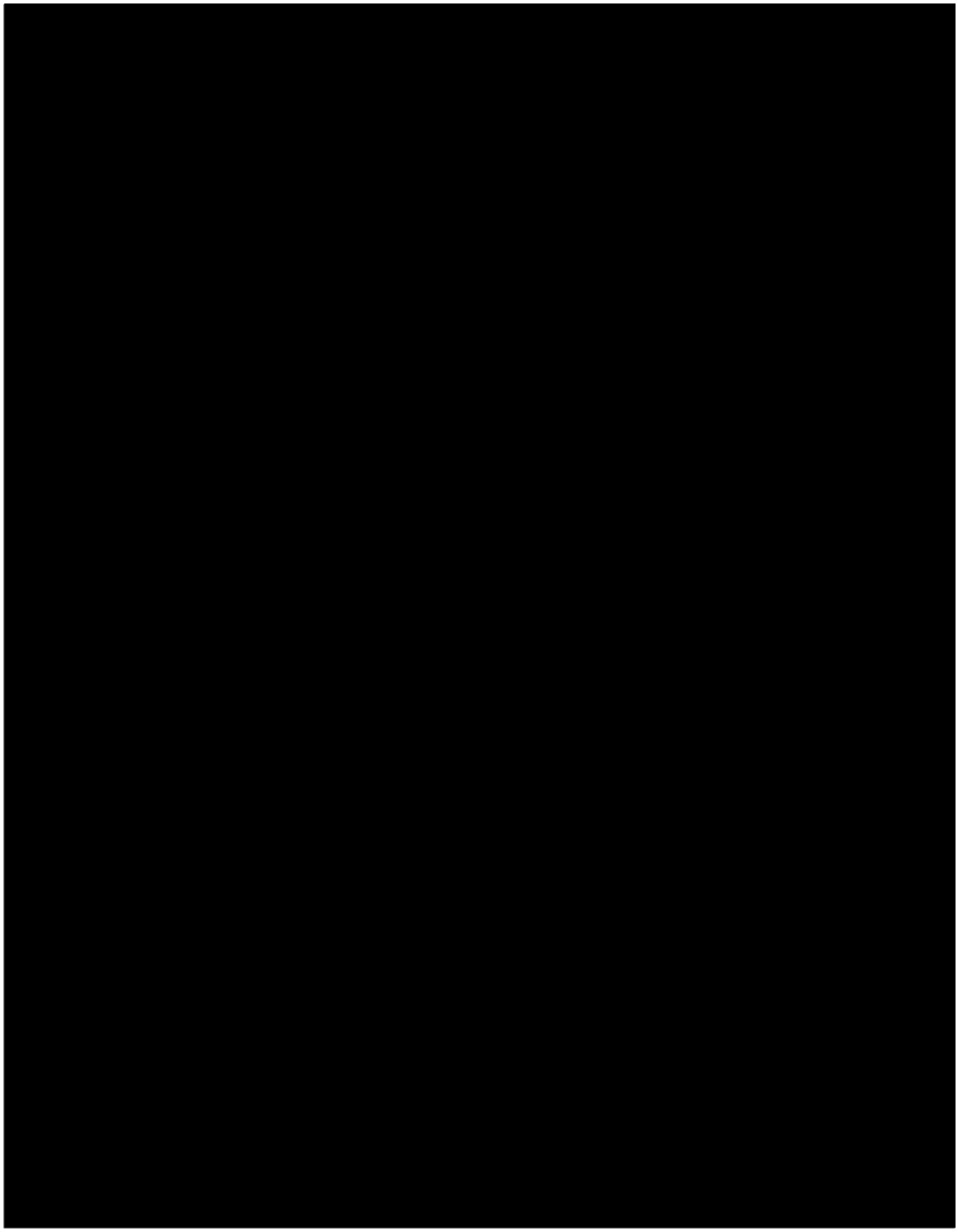
Compliance with Laws

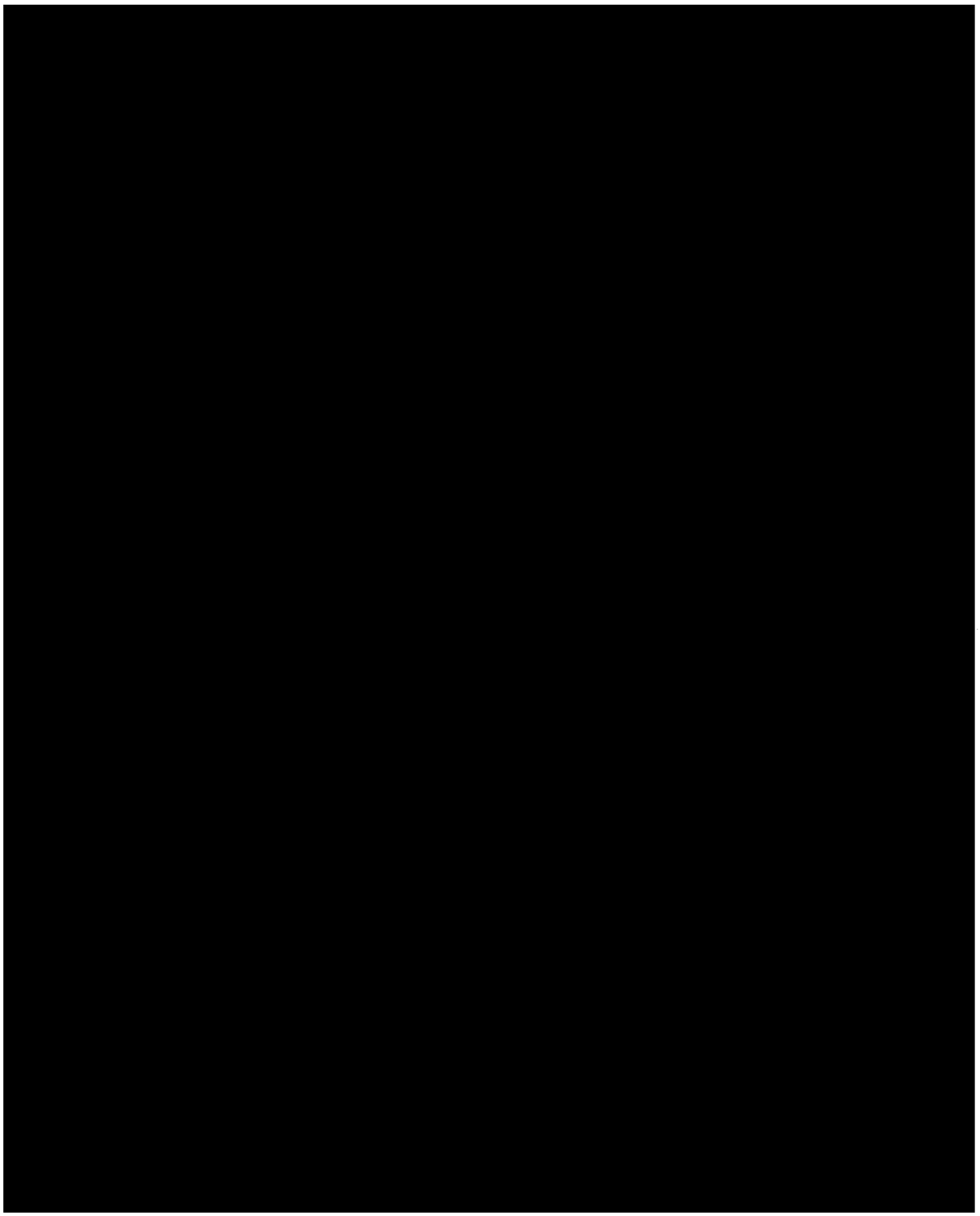
[redacted]

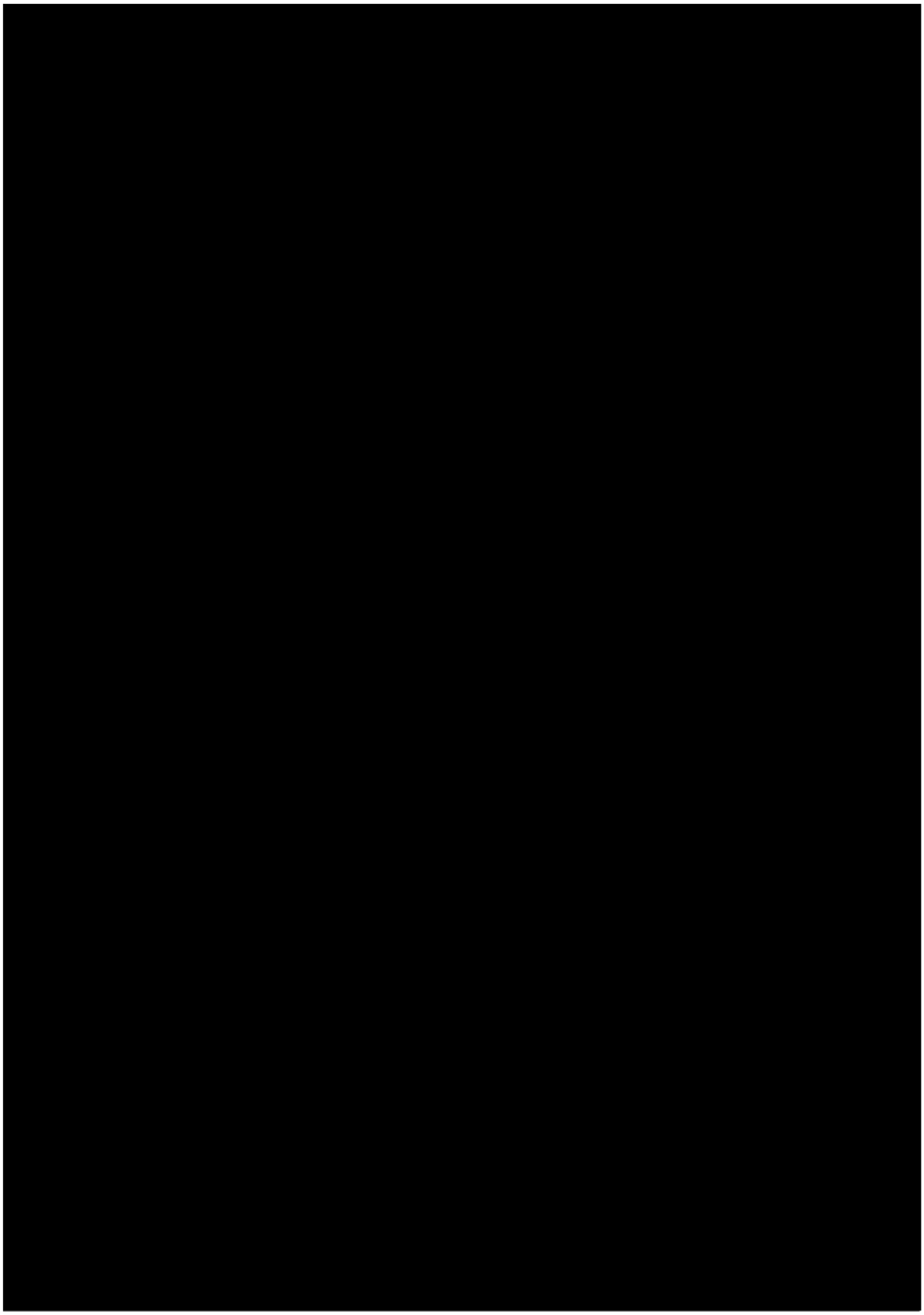


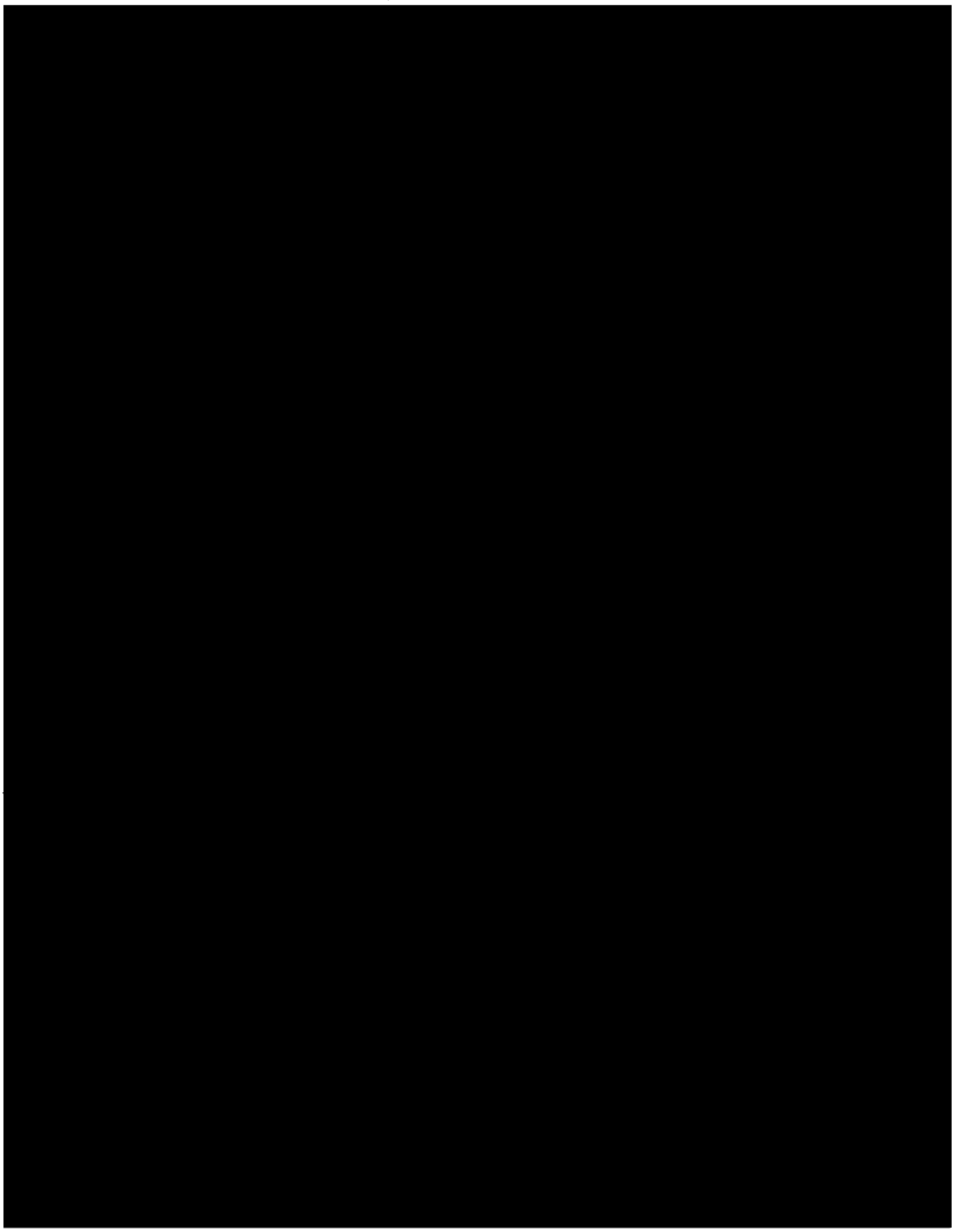












Schedule 6.16(a)

Medicare - Plans of Correction

None.

Schedule 6.16(b)

Medicare - Claims

Other than routine claims for reimbursement before RAC/MAC made in the ordinary course of business and to the knowledge of Saint Mary's, there are no claims, actions, or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures

Schedule 6.16(d)

Medicare - Accreditation Surveys/Deficiency Lists

None.

Schedule 6.19

HIPAA - Breach Notifications

Schedule 6.20

Affiliate Transactions

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

1. James C. Smith -Chairman and CEO of Webster Financial Corporation - Saint Mary's is subject to a loan agreement and revolving note with Webster Bank. See Schedule 6.09

2. S. Mark Albini, M.D. - Dr. Albini provides services to Saint Mary's Hospital pursuant to an Administrative Services Agreement, as amended, between Saint Mary's Hospital and Dr. Albini, dated October 1, 2003. Dr. Albini is also subject to an ACO Medical Director Agreement with Saint Mary's Physician Partners, dated December 1, 2014

3. James Uberti, M.D. - Dr. Uberti provides physician services to Franklin Medical Group pursuant to a Physician Employment Agreement, as amended, by and between Dr. Uberti and Franklin Medical Group, dated October 1, 2012

4. Michael Karnasiewicz, M.D. is the president of Neuro Enterprises, LLC which is party to a Neurosurgery Service Line Co-Management Agreement, dated May 1, 2015, by and between Saint Mary's Hospital, Inc., and Neuro Enterprises, LLC

Franklin Medical Group, P.C.

The following physicians sit on the Board of Directors for Franklin Medical Group, P.C. and are also subject to employment agreements with Franklin Medical Group. See **Schedule 6.09.**

1. Rohit Beri, M.D.

2. Laura Brenes, M.D.

3. Philip Corvo, M.D.

4. Jason Ouellette, M.D.

5. Alex Palesty, M.D.

6. Michael Simms, M.D.

7. John Testa, M.D.

8. Steven Schneider, M.D.

9. James Uberti, M.D. - See above

Schedule 6.21(e)

Environmental

1. Underground Storage Tank Closure/Installation Report, dated November 25, 1997, prepared by Coneco Environmental Corporation – CT

2. Fuel Analysis Report, dated January 27, 2011, for 20,000-gallon No. 2 oil tank and 5,000-gallon diesel tank

3. Certified Tank Tightness Inspection Report, dated January 14, 2011, for the 5,000-gallon diesel generator tank

4. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 5,000-gallon diesel generator tank

5. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 20,000-gallon No. 2 fuel oil tank

6. Cathodic Test inspection Report, dated December 3, 2010, for the 20,000-gallon No. 2 Oil Tank and the 5,000-gallon diesel fuel tank

7. Saint Mary's Hospital Asbestos Operations and Maintenance Program, Revision date July 1993

8. Asbestos Building Assessment, dated July 1990, prepared by TRC Environmental Consultants, Inc.

9. Operations and Maintenance Program (for Asbestos-Containing Materials), dated September 1990, prepared by TRC Environmental Consultants, Inc.

10. Letter, dated August 3, 1990, from Asbestos Abatement & Insulation Services, Inc. re: asbestos abatement contract for the Xavier Attic at Saint Mary's Hospital

11. Asbestos Abatement Monitoring and Pre-Renovation Documents for Saint Mary's Elevator Lobby, dated August 19, 2008, prepared by Eagle Environmental

12. Asbestos Removal Specifications for Slocum 4, dated August 7, 1998

13. Asbestos Operations and Maintenance Program, undated

14. Asbestos Disposal and Documentation Form, #22762, dated October 23, 2008

15. Asbestos Disposal and Documentation Form, #99 91358, landfill date November 18, 2005

16. Asbestos Disposal and Documentation Form, #99 63869, landfill date November 18, 2005

17. Final Report for Asbestos Abatement Project, Emergency Room Phase IIA, dated November 29, 2005, prepared by EnviroScience Consultants Inc.

18. Letter from White Insulation, Inc., dated March 10, 2010, enclosing paperwork re: removal and disposal of asbestos containing materials from the Lawlor Building

19. Letter from White Insulation, Inc., dated August 28, 2008, enclosing paperwork re: removal and disposal of asbestos containing materials from the fourth floor of Saint Mary's Hospital

20. Pre-Renovation Hazardous Building Materials Inspection of Saint Mary's Existing Main Entrance Lobby, dated June 27, 2007, prepared by Eagle Environmental, Inc.

21. Bulk Sample Collection and Analysis of Central Supply Decontamination Room, dated December 13, 2007, prepared by Eagle Environmental, Inc.

22. Bulk Sample Collection and Analysis of Saint Mary's Front Entrance, dated May 16, 2007, prepared by Eagle Environmental, Inc.

23. Hazardous Building Materials Inspection, Abatement Design and Monitoring Services of Saint Mary's Existing Main Entrance Lobby, dated May 16, 2007, prepared by Eagle Environmental, Inc.

24. Proposal from Eagle Environmental, Inc., dated January 25, 2008, re: Asbestos Containing Materials Re-occupancy Services

25. Bulk Sample Collection and Analysis of Kenny Building-2nd Floor Operating Room, dated January 11, 2008, prepared by Eagle Environmental, Inc.

26. Limited Asbestos Inspection Report, dated June 4, 2010, prepared by Superior Industries LLC

27. Letter from White Insulation, Inc., dated August 28, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

28. Asbestos Analysis of Bulk Materials in the Kenny Building and Conference Center 5th Floor, dated February 10, 2010, prepared by Superior Industries L.L.C.

29. Letter from White Insulation, Inc., dated July 17, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

30. Letter from White Insulation, Inc., dated October 19, 2006, enclosing a copy of a waste manifest for asbestos containing materials removed from Saint Mary's Hospital

31. Letter from White Insulation, Inc., received by Saint Mary's on June 27, 2007, enclosing paperwork re: removal and disposal of asbestos containing materials from Saint Mary's

32. Letter from ChemScope, dated May 27, 1994, re: bulk asbestos samples from Saint Mary's Hospital

33. Asbestos Pre-Renovation Inspection for O'Brien Roof Renovation, dated June 4, 2004, prepared by ChemScope

34. Asbestos Removal Monitoring for O'Brien Building for May 29, 1997 to July 11, 1997, prepared by ChemScope

35. Bulk Sample Collection and Analysis of Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

36. Letter from Superior Industries, L.L.C., dated December 15, 2010, re: asbestos testing in Xavier Room 232A area

37. Letter from White Insulation, Inc., dated October 23, 2007, enclosing waste manifest for asbestos containing materials abated at Saint Mary's

38. Asbestos Analysis of Bulk Materials in Xavier, dated January 8, 2011, prepared by Superior Industries L.L.C.

39. Letter from Eagle Environmental, Inc., dated September 6, 2007, re: proposal to provide a pre-renovation asbestos containing materials

40. Asbestos Removal Manual for Saint Mary's Foyer Renovation, prepared by Eagle Environmental, Inc.

41. Letter from Eagle Environmental, Inc., dated August 1, 2007, re: proposal to provide asbestos abatement services for the renovation of the Main entrance lobby

42. Bulk Sample Collection and Analysis for Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

43. Asbestos Disposal and Documentation Form, #142365, landfill date August 11, 2008

44. Asbestos Disposal and Documentation Form, #142366, landfill date August 11, 2008

45. Asbestos Disposal and Documentation Form, #142354, landfill date August 11, 2008

46. Uniform Hazardous Waste Manifest, # 002053366, landfill date September 15, 2008

47. Letter from ChemScope, dated July 30, 1993, enclosing copy of Asbestos O&M Program

48. Restatement of Policy Requirements for handling the spray on fireproofing found in the ceiling spaces of the O'Brien Building, floors 6, 7, and 8, dated April 16, 1991, prepared by TRC Environmental Consultants, Inc.

49. Report from TRC, dated January 21, 1986, re: asbestos project work conducted at Saint Mary's in January 1986

50. Letter from ChemScope, dated December 4, 1991, re: results from bulk samples

51. Letter from ChemScope, dated September 10, 1993, re: results from bulk samples

52. Letter from ChemScope, dated June 13, 1991, enclosing copies of final clearance testing after asbestos abatement for O'Brien 6, 7, and 8 elevator

53. Asbestos Abatement Specifications/Invitation to Bid, prepared by ChemScope Inc., dated March 4, 1991

54. ACM Monitoring Main Entrance Lobby Renovation Project, dated December 20, 2007, prepared by Eagle Environmental, Inc.

55. Bulk Sampling/Analysis Record for Boiler House – New D.A. Tank Room, dated November 20 (year unclear – possibly 1992)

56. Asbestos Abatement Report for MOB Elevator Lobby and CAT Scan, dated December 17, 1993, prepared by AEGIS Inc.

57. Report, dated August 4, 1994, prepared by ChemScope re: Asbestos Removal Monitoring of O'Brien 6-Mechanical Rooms and Adjacent Office Asbestos Removal Monitoring from June 13, 1994 through July 30, 1994

58. Asbestos Removal Specifications for O'Brien 6, dated May 2, 1994

59. Asbestos Abatement Report for Xavier Basement Mechanical room, dated March 24, 1994, prepared by AEGIS Inc.

60. Asbestos Abatement Project Site Monitoring Report for December 18, 1995 through February 8, 1996 for O'Brien 7, prepared by Mystic Air Quality Consultants, Inc.

61. Final Documentation Package for Asbestos Removal in MOB Elevator Lobby and CAT Scan, dated January 7, 1994, prepared by Haz-Pros, Inc.

62. Letter from AAIS, dated February 16, 1994, enclosing disposal documentation for various asbestos abatement and removal projects at Saint Mary's Hospital

63. Asbestos Removal Specifications for Xavier Attics, dated July 25, 1990

64. Certificate of Completion and Disposal Documentation Form for Abatement of Nun's Dining Room, dated October 1990

65. Letter from Acstar Insurance Company, dated July 10, 1991, re: status of bond concerning the Xavier and Slocum Basements

66. AAIS Certification of Payment of all Debts and Claims concerning Slocum and Xavier Basements, dated June 26, 1991

67. Letter from TRC, dated August 15, 1990, re: Justification for Alternative Work Practices

68. Letter from TRC, dated November 6, 1990, re: Completion of Asbestos Abatement of Slocum and Xavier Crawlspaces

69. AAIS Certification of Completion of abatement of crawl spaced, received October 26, 1990, enclosing copy of the Asbestos Abatement Project Notification Form and Asbestos Disposal and Documentation Form

70. Report on Fibrous Dust in Air Analysis, dated October 16, 1990, prepared by Environmental Hazard Control Associates, Inc.

71. Performance Bond, dated September 20, 1990, issued by the American Institute of Architects to AAIS in the amount of $38,500.00

72. Documentation of Approved Disposal of Asbestos Waste, dated September 1990 and October 1990

73. Asbestos Abatement Project Notification Form for work to be completed by September 5, 1990 (may be duplicate of Xavier Attic)

74. Asbestos Removal Specifications for Saint Mary's Penthouse, dated August 7, 1990, prepared by ChemScope

75. Final Inspection of Asbestos Clean-up Action, dated June 20, 1989, prepared by Statewide Environmental Services re: clean-up of electrical box

76. Approval for Special Waste Disposal – Asbestos, dated September 30, 1987, issued by the CTDEP

77. Letter from Saint Mary's, dated January 15, 1988, re: asbestos removal at Saint Mary's Hospital

78. Letter from Marsh &McLennan, dated January 26, 1988, re: asbestos removal at Saint Mary's Hospital

79. Letter from Manville Property Damage Settlement Trust, dated August 7 1989, re: filing first-cycle claims

80. Letter from Saint Mary's, dated July 20, 1987, re: scope of asbestos removal in boiler room and adjacent areas

81. Letter from Sitewide Environmental Services, dated May 19, 1988, re: disposal of asbestos from Saint Mary's at S&S Landfill in Clarkburg, West Virginia

82. Saint Mary's internal memorandum, dated March 29, 1988, re: amount of liability insurance for asbestos removal project

83. Saint Mary's internal memorandum, dated January 25, 1989, re: asbestos removal from the gift shop

84. Asbestos Removal Documentation for removal of 40 linear feet of asbestos pipe covering in March/April 1989

85. Non-hazardous Special Waste Manifests, dated November 19, 1990

86. Invoice from Ever Clear, dated April 30, 1990, re: removal of 135 feet of pipe covering

87. Asbestos removal documentation from Ever Clear re: removal of asbestos from valves and tees in mechanical room

88. Asbestos Fiber Analysis by Transmission Electron Microscopy, Selective Area Electron Diffraction and Energy Dispersive X-Ray Microanalysis, dated August 11, 1990, prepared by EMSL

89. Asbestos Preventative Maintenance Record, dated June 23, 1989, re: asbestos removal from pipe located in Xavier Attic for 3 inch steam line repair

90. Asbestos Preventative Maintenance Record, dated September 1, 1987, to change pressure regulating valve on heating system

91. Asbestos Preventive Maintenance Record, dated March 3, 1987, to remove make up water pump

92. Asbestos Preventive Maintenance Record, dated January 29, 1987, to make repairs to HAVAC unit

93. Asbestos Preventive Maintenance Record dated January 9, 1987, re: accidentally disturbed asbestos while making plumbing repair over top of boiler

94. Asbestos Preventive Maintenance Record, dated June 11, 1986, re: high pressure steam line leaking

95. Asbestos Preventive Maintenance Record, dated June 9, 1986, re: steam leak

96. Saint Mary's Interoffice Memorandum, dated January 13, 1986, re: removal of four barrels of asbestos

97. Approval for Special Waste Disposal Asbestos, dated May 13, 1985, issued CTDEP

98. Asbestos Preventive Maintenance Record, dated August 7, 1985, re: removal of duct to incinerator double plastic

99. Asbestos Preventive Maintenance Record, dated July 29, 1985, re: future removal of incinerator in School of Nursing

100. Asbestos Preventive Maintenance Record, dated March 9, 1985, re: removed asbestos because it was loose

101. Asbestos Preventive Maintenance Record, dated January 17, 1985, re: notification by manufacture and insulation replacement provided by Air Shield

102. Asbestos Preventive Maintenance Record, dated September 11 and 12, 1984, re: facilitate removal of head from heat exchanger in OB-SB

103. Asbestos Preventive Maintenance Record, dated January 25, 1984, re: remove pipe insulation to disconnect chill water coil

104. Asbestos Preventive Maintenance Record, dated January 2, 1984, re: water leak in SA city water bypass

105. Asbestos Preventive Maintenance Record, dated December 20, 1983, re: removal of asbestos from piping on hot water heater

106. Charge ticket from City of Waterbury – Solid and Liquid Waste Disposal, dated October 23, 1985

107. Approval for Special Waste Disposal – Asbestos, dated May 11, 1987, issued by the CTDEP

108. Saint Mary's Policy re: A.C.M. Asbestos Containing Material, dated December 30, 1985

109. Saint Mary's Interoffice Memorandum, dated June 20, 1983, re: asbestos removal on June 16, 1983

110. Saint Mary's Engineering Policy and Procedure Manual, dated December 6, 1983, re: Removal of Asbestos Insulation

111. Saint Mary's Interoffice Memorandum, dated April 21, 1980, re: Asbestos Fiber Containment

112. Saint Mary's internal memorandum, dated April 4, 1985, re: asbestos tests

113. Asbestos Removal Monitoring invoices, contracts, specifications, laboratory results, pre-abatement inspections and project summaries for the Courtyard Roof and Dietary Mechanical Room, dated December 1992 – February 1993

114. Ambient Air Asbestos Testing, Asbestos Project Summaries, Air Samples, Asbestos Worker Certifications, dated January 1992 – March 1992 and CTDPH Application for Approval of Alternative Work Practice, dated December 26, 1991

115. Asbestos Removal Monitoring for the Boiler Room Office, DA Tank Room and O'Brien 4 Mechanical Room, dated February 1, 1993 – February 4, 1993

116. Asbestos Disposal & Documentation Form, dated August 27, 1993

117. Asbestos Disposal & Documentation Form, dated August 11, 1993

118. Asbestos Abatement Report, MRI Hall, KB49 and KB50 prepared by Aegis, Inc. Environmental Consultants, dated November 4, 1993

119. Asbestos Disposal & Documentation Form, dated November 8, 1993

120. AEGIS Analytical Report, dated November 1993

121. Logano Asbestos Disposal & Documentation Form, dated November 8, 1993

122. AAIS Certificate of Completion, dated August 25, 1993, for asbestos removal on 1st & 2nd Floors of O'Brien Wing

123. AAIS Proposed Scope of Work letter, dated May 18, 1993, for the elevator lobby on 5th floor

124. AAIS Certificate of Completion and related documentation for Kinney X-Ray 4 & 5, dated November 1, 2004

125. ChemScope Asbestos Pre-Renovation Inspection for Kenny 1 Radiology Hallways Floor Tile, dated November 19, 2004

126. ChemScope Bulk Sample Identification and Findings, dated July 10, 1996

127. ChemScope Asbestos Abatement Specifications for O'Brien 8 (no drawings included), dated October 28, 1996

128. ChemScope Asbestos Removal Specifications for O'Brien 8, dated October 28, 1996

129. ChemScope Asbestos Removal Specifications for O'Brien 8, dated July 24, 1997

130. ChemScope Bulk Sample Identification and Findings, dated March 6, 1992

131. ChemScope Monitoring and Air Sampling for Mammography and Elevators 9 and 10, dated March 16, 1992 – March 17, 1992

132. ChemScope Monitoring and Air Sampling for ER Radiology Sections I & II, dated April 20, 1992 – April 21, 1992

133. AAIS Certificate of Completion for Asbestos Removal at the 3rd Floor Garage Elevator / Sections I & II Lobby, dated August 1992

134. ChemScope Bulk Sample Identification and Findings, dated November 23, 1992

135. Saint Mary's Bulk Sampling / Analysis Record Results for Boiler House – New D.A. Tank Room, dated November 13, 1992

136. AEGIS Air Monitoring Report, dated February 5, 1993

137. ChemScope Bulk Sample Identification and Findings, dated January 13, 1992

138. ChemScope Bulk Sampling / Analysis Record for O'Brien 5, dated January 13, 1992

139. CT Department of Health Services Asbestos Abatement Notification Form, dated July 22, 1991

140. Logano Asbestos Disposal & Documentation form, dated March 20, 1992

141. Logano Asbestos Disposal & Documentation forms, dated March 5, 1992

142. AAIS Certificate of Completion for Asbestos Removal at O'Brien Cafeteria Entrance, O'Brien Basement and O'Brien Subbasement Connector, dated March 30, 1992

143. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

144. ChemScope Air Sampling Results for 3rd Floor Garage Elevator Area Sections I and II, dated July 11, 1992

145. AEGIS Analytical Reports, dated March 5, 1992

146. ChemScope Bulk Sample Identification and Findings, dated July 28, 1992

147. Asbestos Abatement Specifications for the O'Brien Laboratory Department, 2nd Floor, dated November 8, 1991

148. ChemScope Bulk Sample Identification and Findings, dated November 25, 1991

149. TRC Request for Confirmation regarding asbestos work in the Basement and 5th Floor, dated January 29, 1991

150. ChemScope Ambient Asbestos Air Samples, dated July 23, 1990

151. TRC Asbestos Building Assessment, dated July 1990

152. TRC Summary Report – Quarterly Air Monitoring, dated June 1991

153. TRC Summary Report – Asbestos Removal Activities, dated December 1990

154. TRC Summary Report – Quarterly Air Monitoring, dated January 1991

155. AEGIS Report of Ambient Air Sampling, dated December 10, 1991

156. ChemScope Asbestos Sample Identification, dated October 31, 1991

157. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

158. Various Basement Sampling Results, dated December 27, 1991

159. ChemScope Bulk Sample Identification and Findings, dated May 28, 1991

160. ChemScope Bulk Sample Identification and Findings, dated April 1991

161. EnviroMed Laboratory Analysis Reports, dated April 1991

162. Declaration of Fran Fahy that there is asbestos in the ceiling of Radiation Therapy, dated September 11, 1990

163. Ever Clear Final Sample Test Report, dated May 31, 1990

164. ChemScope Post Abatement Asbestos Air Samples, dated August 31, 1990

165. ChemScope Asbestos Removal Monitoring for the Boiler Room, dated August 23, 1990

166. ChemScope Ambient Air Samples from Boiler Room, dated July 23, 1990

167. ChemScope Asbestos Air Samples, dated April and May 1988

168. Statewide Environmental Services Air Sampling for Friable Asbestos, dated October 3, 1988

169. ChemScope Asbestos Removal Monitoring for Xavier Attics North/South, dated September 1, 1990

170. Saint Mary's Memorandum regarding TRC Air Samples, dated August 7, 1990

171. TRC Verification of Sample Analysis for debris in the Boiler Room, dated July 25, 1990

172. TRC Physician's Notification of Requirement of Physical Examinations, dated April 16, 1991

173. TRC Completion of Asbestos Removal and Cleanup for the Boiler Room and Xavier North/South Attics, dated September 14, 1990

174. TRC letter regarding properly managing asbestos and the Hospital's liability, dated July 30, 1990

175. TRC handwritten letter regarding the floor locations to be inspected as part of the Asbestos Management Program, dated August 10, 1990

176. ChemScope Asbestos Removal Specifications for the Kenny Basement, dated May 29, 1997

177. ChemScope Asbestos Removal Specifications OB SB-1, Mechanical Room, K1 Radiology Rooms 1 & 2, Dark Room, Slocum Pipe Chase Levels B thru 4 and SH Condensate Pump Room, dated January 30, 1997

178. Asbestos Removal and Area Decontamination – Supplementary General Conditions (starts with Table of Contents)

179. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 8, 1997 through July 9, 1997, dated July 23, 1997

180. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 10, 1997 through July 16, 1997, dated July 23, 1997

181. ChemScope Final Clearance Testing After Asbestos Abatement, dated July 21, 1997

182. ChemScope Asbestos Bulk Sampling for O'Brien 6 Penthouse (mud on exposed ends of fiberglass insulated lines adjacent to heating and chilled water pumps), dated November 13, 2001

183. ChemScope Asbestos Bulk Sampling for O'Brien 5 PT Gym Room Floor Tile and Mastic, dated November 29, 2001

184. Certificate of Completion and related documents for O'Brien 1st Floor, dated April 4, 2001

185. Certificate of Completion and related documents for Kenny Basement Stairwell Tile, dated October 11, 2000

186. Certificate of Completion and related documents for Pick Up & Disposal, dated August 10, 2000

187. ChemScope Asbestos Pre-Renovation Inspection for O'Brien 1 – Inpatient Mental Health – Hellman Pavilion, dated February 11, 1999

188. Asbestos Air Monitoring, dated February 22-23, 1999, prepared by Dale Environmental, Inc.

189. ChemScope Bulk Sampling / Analysis Record for O'Brien - Inpatient Mental Health – Hellman Pavilion, dated February 1999

190. Asbestos Inspection, dated February 3, 1999, prepared by Dale Environmental, Inc.

191. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #5, dated July 16, 1999

192. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #4, dated July 16, 1999

193. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #1, dated July 16, 1999

194. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #3, dated July 16, 1999

195. Asbestos Abatement Specification for Cardiac Cath Lab, 2nd Floor, Sacred Heart Building, dated February 1999, prepared by Dale Environmental, Inc.

196. ChemScope Asbestos Pre-Renovation Inspection for Xavier 1 Auxiliary Office Area, dated February 12, 1998

197. ChemScope Asbestos Removal Monitoring for February 21, 1997 through March 8, 1997, dated March 31, 1997

198. Internal Memorandum regarding the Status of the Manville Property Damage Settlement Trust and related documents including claim payment information, dated 1996-1997

199. ChemScope Bulk Sample Identification and Findings (submitted as evidence for the Manville Property Damage Settlement), dated July 27, 1991 – May 13, 1995

200. AEGIS Certificate of Visual Inspection, dated March 23, 1994

201. Notification to the EPA of Demolition and Renovation Activities for MRI-KB, dated October 1, 1993

202. List of Asbestos Removal Areas/Costs from 1987 to Present, dated February 26, 1991

203. List of Asbestos Monitoring Areas/Costs from July 1990 to Present, dated February 26, 1991

204. AAIS Certificate of Completion of Asbestos Removal at Saint Mary's Hospital O'Brien Elevator Project and related Asbestos Disposal & Documentation Forms and Asbestos Abatement Notification Form

205. Letter from ChemScope, dated April 17, 1989, re: Asbestos Identification in Samples

206. Letter from TRC, dated November 30, 1990, re: Draft Scope of Asbestos Work

207. Letter from TRC, dated October 3, 1990, re: Saint Mary's Hospital Asbestos Management Program

208. Letter from Cannon, dated August 14, 1990, re: vinyl asbestos tile in the Kenny Pavilion

209. Letter from TRC, dated August 10, 1990, re: Inspections of Parking Garage and Convent Building

210. Letter from ChemScope, dated July 22, 1990, re: Air Monitoring at Saint Mary's Hospital Boiler Room Asbestos Removal, Pipe Residuals

211. Letter from TRC, dated December 18, 1990, re: completion of removal of vinyl asbestos floor tile from the old vending machine room

212. ChemScope Certificate of Analysis, dated February 17, 1998, re: bulk samples collected on February 12, 1998

213. Asbestos Disposal and Documentation Form, dated January 21, 1997

214. Asbestos Disposal and Documentation Form, dated September 6, 1996

215. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Marley Tower in September 1991

216. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Quality Assurance Office Area 2 in July 1991

217. AAIS Certificate of Completion, dated November 23, 1993, re: asbestos removal at MRI KB-49 and KB-50

218. Letter, dated August 6, 1990, from TRC Environmental Consultants, Inc. re: Transmission Electron Microscope Analysis of Air Samples

219. Asbestos Disposal & Documentation Form for the Xavier Attic

220. Asbestos Abatement Project Notification Form for the Xavier Attic

221. Asbestos Project Summary and Asbestos Preabatement Inspection, prepared by ChemScope, for the Xavier Attic

222. ChemScope Asbestos Pre-Renovation Inspection for Roof Renovation – O'Brien 8 Roof, dated June 2004

223. American Hospital Association letter regarding Claim Forms for Filing Claims with the Manville Property Damage Settlement Trust, dated May 1985

224. Specifications for Procedures to Prevent Asbestos Contamination and Exposure During Containment Construction for Asbestos Abatement Work, dated August 1990

225. NHD Waste Shipment Record, dated July 16, 1997

226. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #2, dated July 16, 1999

227. Notification of Regulated Waste Activity, dated January 12, 2000

228. Saint Mary's Hospital Hazardous Materials Management Program, dated March 5, 2009; Revised March 6, 2009

229. 2009 Biennial Hazardous Waste Report for Saint Mary's Hospital, submitted by GZA GeoEnvironmental, Inc. on February 26, 2010

230. Budgetary Quotation, dated February 25, 2010, from United Industrial Services to Saint Mary's Hospital

231. Course Outline for Saint Mary's Hospital Hazardous Waste Training RCRA-OSHA-DOT Sessions 1, 2, and 3

232. List of Hazardous Material and Waste Storage Areas

233. Tier II Emergency and Hazardous Chemical Inventory Form Certification for Reporting Year 2009

234. Anesthetic Waste Gas Monitoring Report, dated November 2, 2009, prepared by Praxair

235. Anesthetic Waste Gas Monitoring Report, dated May 1, 2009, prepared by Praxair

236. Ethylene Oxide Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

237. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2007

238. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2006

239. Compliance Indicator Survey Information Sheet/Hazardous Waste Partial Compliance Evaluation for Saint Mary's Hospital, dated June 27, 2006

240. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2005

241. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2003

242. CT DEP Permit to Operate a Caterpillar D-349 Diesel Generator, No. 192-0093

243. CT DEP Permit to Construct and Operate a Caterpillar Model 3508TA diesel standby generator, No. 192-0116

244. Saint Mary's Compliance Plan for Connecticut Regulations for the Control of Oxides of Nitrogen, dated August 1994

245. Pre-Inspection Questionnaire (PIQ) for Calendar Year 1999

246. Pre-Inspection Questionnaire Report for Inspection Date June 28, 2000

247. Notice of CT DEP Air Inspection, dated March 26, 2004

248. Pre-Inspection Questionnaire (PIQ) for Calendar Year 2003

249. Letter, dated May 7, 2010, from GZA to Saint Mary's Hospital Re: Results of Greenhouse Gas Emissions Evaluation

250. Registration/Application to Seek Coverage Under the General Permit to Limit Potential to Emit for Saint Mary's Hospital, dated March 2006

251. Approval of Registration for General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, Effective Date June 15, 2006

252. CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, issued November 19, 2010

253. 2009 Annual Compliance Certification Form for CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution

254. Letter from GZA, dated January 20, 2011, re: 2010 GPLPE Annual Compliance Certification

255. Letter from CTDEP, dated January 8, 2008, re: notice of plant inspection on March 12, 2008

256. Indoor Air Quality Survey, dated May 6, 2009, for Lawlor Building

257. Environmental Testing at Saint Mary's Hospital re: Air Change Rates/Indoor Air Quality, dated February 2007, prepared by Praxair

258. Formaldehyde Vapor Analysis Reports, dated April 16, 2008, prepared by Praxair

259. Air Change Rate Report, dated May 1, 2009, prepared by Praxair

260. Acetic Acid & Hydrogen Peroxide lab Results Report, monitoring date May 26, 2009, prepared by Praxair

261. Fume Hood Environmental Monitoring Report, dated March 22, 2006, prepared by Praxair

262. Environmental Monitoring at Saint Mary's Hospital re: Air Change Rates, Indoor Air Quality, and Microbiological/Mold, dated March 2008, prepared by Praxair

263. Environmental Monitoring for Saint Mary's Child Development Center re: Air Change Rates and Indoor Air Quality, dated November 2007, prepared by Praxair

264. Environmental Monitoring for Saint Mary's Hospital re: Air Change Rates and Indoor Air Quality, dated January and February 2008, prepared by Praxair

265. Fume Hood Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

266. Fume Hood Environmental Monitoring Report, dated November 2, 2009, prepared by Praxair

267. Air Change Rate Report, dated November 2, 2009, prepared by Praxair

268. Air Change Rate Report, dated March 22, 2006, prepared by Praxair

269. Environmental Monitoring Report for Fume Hood, dated June 2010, prepared by Praxair

270. 2008 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

271. 2006 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

272. Boiler Operating Certificates 1995-2010

273. State of Connecticut DEP-Air Management Bureau-Hartford Premise Evaluation Report for inspection date April 26, 2004

274. 2005 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

275. 2004 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

276. 2003 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

277. 2002 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

278. 2001 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

279. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 2000

280. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1999

281. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1998

282. Letter from the City of Waterbury, dated January 23, 2001, re: cross connection inspection

283. Letter from the City of Waterbury, dated January 18, 2001, re: test results from November 28, 2000 backflow prevention test

284. Letter from the City of Waterbury, dated January 5, 2000, re: test results from November 29, 1999 backflow prevention test

285. Letter from the City of Waterbury, dated June 22, 1998, re: test results from May 19, 1998 backflow prevention test

286. Letter from the City of Waterbury, dated January 7, 1998, re: test results from the reduced pressure backflow preventer testing on November 26 and 28, 1997

287. Letter from the City of Waterbury, dated March 26, 1997, re: test report from backflow prevention testing on March 26, 1997

288. Letter from the City of Waterbury, dated January 14, 1997, re: test results from November 29, 1996 backflow prevention test

289. Letter from the City of Waterbury, dated January 22, 1996, re: test results from November 24 and 26, 1995 backflow prevention tests

290. Letter from the City of Waterbury, dated January 22, 1996, re: violations detected during November 26, 1995 backflow prevention test

291. Letter from the City of Waterbury, dated January 31, 1996, re: compliance confirmed during reinspection conducted on November 24 and 25, 1995

292. Registration Form for Reauthorization Under the Domestic Sewage General Permit

293. Minor Photographic Processing General Permit for the Hospital (Certificate of Registration; General Permit Application No. 200700007; and Certification Form GPH2)

294. Minor Photographic Processing General Permit for the Dental Clinic (Certificate of Registration; General Permit Application No. 200700005; and Certification Form GPH2)

295. Minor Photographic Processing General Permit for the Naugatuck Walk-in Center (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700008; and Certification Form GPH2)

296. Minor Photographic Processing General Permit for Franklin Surgical Site (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700006; and Certification Form GPH2)

297. Letter, dated March 9, 2007, from GZA to City of Waterbury Water Pollution Control re: Minor Photographic Processing Wastewater Discharge at Saint Mary's Hospital

298. 1996 Industrial/Commercial Sewer Use Certification Statements for Saint Mary's Hospital and its related properties

299. 1995 Sewer User Certification Statement for Saint Mary's Hospital

300. Materials License, No. 06-00679-01, dated April 24, 2007, issued by the U.S. Nuclear Regulatory Commission (as amended by Amendment No. 55)

301. Ionizing Radiation Registration, dated December 30, 2009; Submitted to the CT DEP on January 1, 2010

302. Saint Mary's Hazardous Waste Disposal (Radioactive) Policy, revised April 2006

303. Saint Mary's Radioactive Contaminated Objects Waste Disposal Policy, dated December 2010

304. Hazardous Substance Certificate and Indemnification Agreement, dated June 28, 1991

305. Phase II Subsurface Investigations Report, 51 North Elm Street, Waterbury, Connecticut, dated July 26, 2007, prepared by HRP Associates, Inc.

306. Subsurface Investigation Report, dated January 11, 2008, prepared by GeoInsight for 51 North Elm Street, Waterbury, Connecticut

307. Memorandum, dated January 14, 2008, prepared by GeoInsight re: break down of the estimated remediation costs for 51 North Elm Street, Waterbury, Connecticut

308. Letter, dated February 1, 2008, from GeoInsight re: proposal for subsurface remedial investigation, design, and implementation services for 51 North Elm Street, Waterbury, Connecticut

309. Escrow and Release Agreement, dated February 11, 2008, for 51 North Elm Street, Waterbury, Connecticut

310. Memorandum, dated February 14, 2008, from GeoInsight re: Proposed Work Schedule for 51 North Elm Street, Waterbury, Connecticut

311. HRP Associates, Inc.'s Proposal for Oversight of the Environmental Remediation That Has Been Proposed by GeoInsight for 51 North Elm Street, Waterbury, Connecticut, dated March 18, 2008

312. HRP Invoice, dated October 9, 2008, for Project Management Services

313. E-mail, dated February 27, 2009, from HRP Associates, Inc. re: completion of soil remediation at 51 North Elm Street, Waterbury, Connecticut

314. Memorandum, dated March 20, 2009, from GeoInsight re: Pavement Restoration and Compliance/Post Remedial Ground Water Monitoring at 51 North Elm Street, Waterbury, Connecticut

315. E-mails, dated May 13, 2010, May 21, 2010, and May 24, 2010 re: partial disbursement of environmental escrow and retention of $25,000 for 51 North Elm Street, Waterbury, Connecticut

316. Letter, dated June 23, 2010, enclosing a check representing the agreed amount of the environmental escrow release for 51 North Elm Street

317. Payment Notice, dated October 7, 2010, re: GeoInsight invoices for environmental remediation services at 51 North Elm Street, Waterbury, Connecticut

318. E-mail, dated December 22, 2010, from GeoInsight re: 51 North Elm Street-Status of Ground Water Monitoring

319. Saint Mary's Preliminary Mold Inspection of Slocum and Xavier 5, dated January 26, 2006

320. Saint Mary's Preliminary Mold Inspection of Kenny 3, dated September 12, 2006

321. Saint Mary's Preliminary Mold Inspection of Sacred Heart Basement, dated September 14, 2006

322. Mold Environmental Monitoring Report, dated October 15, 2007, prepared by Praxair

323. Mold and Fungi Inspection Report, dated June 4, 2010, prepared by Superior Industries L.L.C.

324. Certificate of Mold Analysis, dated February 10, 2010, prepared by Pro Lab

325. Mold and Fungi Inspection Report, dated July 25, 2008, prepared by Superior Industries L.L.C.

326. Certificates of Mold Analysis, dated July 7, 2008, prepared by Pro-Lab

327. Mold and Fungi Remediation Recommendation Report, dated January 21, 2009, prepared by Superior Industries L.L.C.

328. Mold and Fungi Remediation Recommendation Report, dated May 20, 2009, prepared by Superior Industries L.L.C.

329. Mold and Fungi Inspection Report, dated September 20, 2010, prepared by Superior Industries L.L.C.

330. Certificates of Mold Analysis and Mold Analysis Reports for Pediatric Ward, dated June 25, 2008, prepared by Pro-Lab

331. Lead Analysis Report, dated April 6, 2007, for Drinking Water Child Care Area

332. Raydon and Lead Testing Recommendation Report, dated February 20, 2009, re: Children's Day Care Center

333. Environmental Monitoring at Saint Mary's Hospital, dated September 2006, prepared by Praxair

334. Environmental Monitoring at Saint Mary's Hospital, dated March 2007, prepared by Praxair

335. Environmental Monitoring Reports for anesthetic waste gas, air change rate, ethylene oxide, and fume hood, dated March 2010, prepared by Praxair

336. Laboratory Report – Full Particle Identification for Saint Mary's Hospital Lobby, dated February 5, 2008, prepared by EMSL Analytical, Inc.

337. Fire Marshall Inspection Certificates/Reports for 1994-2010

338. Policyholder Environment of Care Review and Risk Improvement Report, dated February 23, 2010, prepared by Zurich Services Corp.

339. Policyholder Environment of Care Review and Risk Improvement Report, dated April 21, 2009

340. Policyholder Environment of Care Review and Risk Improvement Report, dated May 13, 2008

341. Policyholder Environment of Care Review and Risk Improvement Report, dated May 8, 2007

342. Utilities Management Program for Plant Operations Department

343. Saint Mary's Hospital Environmental Compliance Assistance (internal guidelines)

344. Contract of Sale between Saint Mary's Hospital Corporation and Tom Gessler for Parcel 10B, Abbott Terrace in Waterbury, Connecticut (undated)

345. Phase I Environmental Site Assessment of Saint Mary's Hospital & Adjacent Facilities, dated February 26, 2011, prepared by Environmental Risk Services, LLC (including all Appendices)

346. Letter, dated February 24, 2011, from Environmental Risk Services, LLC to Gobbell Hays Partners, Inc. re: Environmental Summary Report for 290 French Street, Watertown, CT

347. Hazardous Materials Survey Report, dated August 10, 2011, prepared by HRP Associates, Inc.

348. Limited Asbestos—Containing Materials Survey Report, SMRI

349. Sacred Heart Cafeteria Serving Area, dated September 27, 2011, prepared by HRP Associates, Inc.

350. Environmental Reviewed and Phase II Subsurface Investigations Report, dated June 28. 2011, prepared by HRP Associates, Inc.

351. Phase III Subsurface Investigations Report, dated September 28. 2011, prepared by HRP Associates, Inc. (attached as Phase III)

352. Additional Phase III Subsurface Investigations Report, dated March 2, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Additional Phase III Report)

353. Closure Report for Former Less Than 180 Day Hazardous Waste Container Storage Area, dated July 17, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Closure Report)

354. Hazardous Materials Survey Report, dated October 4, 2011, prepared by HRP Associates, Inc.

355. Phase I Environmental Site Assessment Report, dated October 4, 2011, prepared by HRP Associates, Inc.

356. Limited Ground Penetrating Radar (GPR) Survey Report, dated October 11, 2011, prepared by HRP Associates, Inc.

357. 2013 General Permit to Limit Potential to Emit - Annual Compliance Certification Form, dated March 20, 2014

358. 2014 General Permit to Limit Potential to Emit - Emissions Calculator for 2014 Calendar Year, dated February 2015

359. 2013 Tier2 Chemical Inventory Report, dated March 26, 2014

360. 2014 Tier2 Chemical Inventory Report, dated February 18, 2015

Schedule 6.22

Employee Benefit Matters

6.22(a)

1. Paid Time Off (used for vacation, holiday, personal, and sick time)
2. Bereavement Leave
3. Jury Duty Leave
4. Military Duty Leave
5. Pregnancy Leave
6. Donated Time
7. Employee Assistance Plan
8. Health Plan (self-insured)
9. Dental Plan (self-insured)
10. Basic Life Insurance
11. Supplemental Life Insurance
12. Dependent Life Insurance for spouse and/or dependent(s)
13. Short Term Disability
14. Long Term Disability
15. Basic Accidental Death & Dismemberment
16. Voluntary Accidental Death & Dismemberment
17. Discounted YMCA membership
18. Saint Mary's Hospital Retirement Savings Plan
19. Pension Plan for Employees of St. Mary's Hospital Corporation
20. Home & Auto Insurance (paid through payroll deduction)
21. On-site Parking (paid through payroll deduction)
22. Health Care Professional Liability Insurance
23. Excess Medical Professional Liability Insurance

24. Annual License Renewal

25. Flexible Spending Account
    a. Medical
    b. Dependent Care

26. Tuition Reimbursement

27. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan

28. Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plan

29. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013

30. Non-Competition and Severance Agreement for Executive by and between Saint Mary's Hospital, Inc. and Steven Schneider, M.D., dated May 25, 2011

31. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Michael Novak, dated June 20, 2008, as amended

32. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Ralph W. Becker, dated January 27, 2014

33. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital, Inc. and Charles M. Flinn, dated December 12, 2013

34. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and James B. Tucker, dated August 8, 2013

35. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008, as amended

36. Amended and Restated Non-Competition and Severance Agreement for a Director by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008, as amended

37. Retiree medical (self-insured)

38. Retiree life insurance

39. Executive Incentive Plans

To the knowledge of Saint Mary's, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health.

6.22(b)

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

A submission under the IRS's VCP was filed for each of the 401(k) Plan and Pension Plan with the most recent IRS determination letter submission for the plan to correct untimely amendments. A Compliance Statement from the IRS in connection with the VCP submission for the 401(k) Plan was issued on September 14, 2011. A Compliance Statement from the IRS in connection with the VCP submission for the Pension Plan was issued on July 25, 2011.

6.22(c)

None, provided the church plan exemption as described in Schedule 6.07 is legally valid and in effect for the Pension Plan for Employees of St. Mary's Hospital Corporation.

6.22(d)

None.

6.22(e)

The following St. Mary's Benefit Plans are intended to be "church plans:"

St. Mary's Hospital Retirement Savings Plan

Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan")

All health and welfare plans

The Pension Plan's funded status is materially below the 80% standard set forth in the Agreement section 6.22(e), and for which an Agreement Disclosure Schedule exception is now taken.

6.22(f)

All Saint Mary's welfare benefit plans have been considered and treated as exempt Church Plans.

Saint Mary's provides retiree medical and life insurance benefits.

6.22(g)

1. Amended and Restated Non-Competition and Severance Agreement, as amended, by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008
2. Amended and Restated Non-Competition and Severance Agreement for a Vice President, as amended, by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008
3. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Michael Novak, dated June 20, 2008
4. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Steven Schneider, M.D., dated May 25, 2011
5. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Ralph W. Becker, dated January 27, 2014
6. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Charles M. Flinn, dated December 12, 2013
7. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and James B. Tucker, dated August 8, 2013
8. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013
9. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan and Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plans
10. Executive Incentive Plans

6.22(h)

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be

requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.22(k)

None.

Schedule 6.23

Employment Matters

None.

Schedule 6.24

Taxes

1. Failed to file 2009 Form 990 for the Heart Center of Greater Waterbury, Inc.

2. Saint Mary's Hospital was audited by the State of Connecticut for Sales and Use Tax in early 2010 for the calendar years from 12/31/2004 to 12/312009. The Hospital did not remit sales tax collected on certain contract revenues. The audit resulted in a tax of $7,159.86 with penalties and interest of $3,406.15 for a total of $10,566.01. Such tax was paid in full. The Hospital now files those tax returns every year and remits to the State

Schedule 6.25

Insurance

Complete List of Current Insurance/Self-Insurance Policies

1. Workers Compensation and Employers Liability Insurance Policy - Pennsylvania Manufacturers Indemnity Company

2. For all additional policies, see attached.

Pending Claims and Claims History for 10 Year Period Prior to Signing Date

See Attachment to Schedule 6.25

Saint Mary's Health System, Inc.

Summary of Insurance Effective as of July 1, 2015
People's United Insurance Agency

Company	Policy Number	Policy Period	Annual Premium
American Guarantee & Liability Ins Co. (Zurich)	ZMD353933914	10/01/14-15	$191,805 (Includes $3,000 Engineering Fee)

PROPERTY

Coverage	Limit	Deductible
Blanket Building & Business Personal Property		
56 Franklin St Campus & Other Locations per Statement of Values	$375,000,000	$25,000
Business Interruption	Included	
Extra Expense	25,000,000	
Machinery Breakdown	150,000,000	25,000
Earthquake	100,000,000	50,000
Flood	100,000,000	50,000

American Guarantee & Liability Ins Co	BAP932700901	10/01/14-15	$16,330

AUTOMOBILE

Limits	
Bodily Injury & Property Damage Limit (Incl. Hired & Non Owned)	$1,000,000
Medical Payments	$5,000
Uninsured & Underinsured Motorist (Conversion)	$1,000,000
Comprehensive Deductible (full glass)	$500
Collision Deductible	$1,000

Additional Coverage and Exclusions

Rental Reimbursement	$30 Day/$900 Max
Primary Hired Auto Physical Damage	$50,000
Commercial Auto Extension Endorsement	Included
Ambulance and/or Emergency Vehicles	Excluded

GARAGE KEEPERS – DIRECT PRIMARY

Locations:

1. 56 Franklin Street, Waterbury, CT
2. 88 Union Street, Waterbury, CT
3. 133 Scovill Street, Waterbury, CT
4. 100 Union Street, Waterbury, CT
5. 353 East Main Street, Waterbury, CT

Garagekeepers Limit – Each Location

$75,000 Comprehensive ($500 deductible/$2,500 max)
$75,000 Collision ($500 deductible)

Global Aerospace, Inc.	10041881	10/01/14-15	$14,025

HELIPORT LIABILITY

Limits

$10,000,000	Each Occurrence
$ 25,000	Fire Damage Limit (Any One Fire)
$ 10,000	Medical Expense (Any One Person)
$10,000,000	Non Owned Aircraft Liability

ProSelect Insurance Company	PSCCA10201402	10/01/14-15	$935,000

EXCESS LIABILITY

Reinsured: - Saint Mary's Indemnity Company LLC

Limits

$15,000,000	Health Care Professional Liability - Specific Loss Limit
$15,000,000	Health Care Professional Liability - Aggregate Limit
$25,000,000	Other Coverage (GL) – Specific Loss Limit
$25,000,000	Other Coverage (GL) - Aggregate Limit

Underlying Limits

$3,000,000/$14,000,000	Professional Liability (Claims-Made)
$1,000,000/$4,000,000	General Liability (Occurrence)
$1,000,000/$1,000,000	Employee Benefits Liability
$1,000,000	Automobile Liability
$1,000,000/$1,000,000/$1,000,000	Employers Liability
$10,000,000	Helipad Liability
$1,000,000/$2,000,000	Child Development Center General Liability (Occurrence)

Allied World Assurance Company	03086025	10/01/14-15	$50,000

Excess Liability

Limits $5,000,000 XS $15,000,000 Health Care Professional Liability

National Union Fire Insurance Co. of Pittsburgh PA 015933607 10/01/14-15 $110,630

DIRECTORS & OFFICERS LIABILITY/EMPLOYMENT PRACTICES LIABILITY (CLAIMS-MADE)

Limits expenses)	$15,000,000	Each Claim or related Claims and in the policy aggregate (inclusive of defense
	$500,000	EMTALA
	$500,000	HIPAA
Retentions		
	$ 0	Insured Persons
	$250,000	Corporate Indemnification & Insured Entity
	$350,000	Anti-Trust with 75/25 Coinsurance
	$200,000	Employment Practices Liability & Third Party EPL

Allied World National Assurance Company 03059844 10/01/14-15 $20,790

DIRECTORS & OFFICERS SIDE A LIABILITY (CLAIMS-MADE)

Limits	$5,000,000	excess $15,000,000 National Union Fire

Illinois National Insurance Company 02-778-21-50 1/30/15-16 $27,286

FIDUCIARY LIABILITY	$5,000,000	Limit
DEDUCTIBLE	$25,000	

Travelers Casualty & Surety Co. of America 105686950 10/01/14-15 $17,150

CRIME

Limits

$5,000,000	Employee Theft
$5,000,000	ERISA
$5,000,000	Forgery or Alteration
$5,000,000	On Premises
$5,000,000	In Transit
$5,000,000	Money Orders & Counterfeit Money
$5,000,000	Computer Fraud
$100,000	Computer Program & Electronic Data Restoration Expense
$5,000,000	Funds Transfer Fraud
$10,000	Theft of Client Property
$10,000	Theft of Patient Property
$1,000,000	Personal Accounts Forgery or Alteration
$10,000	Claim Expense

DEDUCTIBLES

$ 50,000	
$ 0	ERISA & Claim Expense
$ 500	Theft of Client & Patient Property
$ 1,000	Computer Program & Electronic Data Restoration Expense

KIDNAP & RANSOM

$5,000,000	Kidnap for Ransom
$5,000,000	Extortion for Ransom

IDENTITY FRAUD EXPENSE

$ 25,000	Limit

Beazley/Lloyd's	W104CB150601	1/01/15-16	$49,400 Includes Tax

NETWORK SECURITY/BREACH RESPONSE "CLAIMS MADE"

Limits:	$3,000,000	Per Claim and in the Aggregate, inclusive of:
	3,000,000	Information Security and Privacy Liability
	3,000,000	Website Content Liability
	1,500,000	Regulatory Action Defense & Penalties
	3,000,000	Security Event Data Restoration
	3,000,000	Cyber Extortion
	2,500,000	Aggregate Limit for all Computer Expert Services, Legal Services and Public Relations and Crisis Management Expenses
	250,000	PCI Fines & Penalty Coverage
Retention:	$ 50,000	Per Claim
Includes:	Privacy Breach Response Services, subject to $10,000 Retention each breach: Notification of up to 2 Million Individuals Credit Monitoring for breaches with obligation to notify 100 or more individuals	

Ironshore Specialty Insurance Company (3 Yrs)	000970501	10/01/12–15	$48,338 est. Includes Tax

POLLUTION LEGAL LIABILITY

Limits:	$3,000,000	Third Party Claims for Bodily Injury, Property Damage and Remediation Expenses
	$3,000,000	First Party Remediation Expenses
	$3,000,000	Emergency Response Expenses
	$3,000,000	Business Interruption, 365 Days
	$3,000,000	Disinfection Event Expenses
	$3,000,000	Evacuation Expenses
Deductibles:	$25,000	Each Incident
	5 Days	Business Interruption

Ace American Insurance Company	G24796012001	10/01/14-15	$1,547

STORAGE TANK LIABILITY – Financial Responsibility

Limits:	$1,000,000	Per Storage Tank Incident – Claims & Remediation Costs
	$1,000,000	Aggregate – Claims & Remediation Costs
	$1,000,000	Aggregate Limit for all Legal Defense Expenses
	$2,000,000	Total Policy Aggregate
Deductible:	$5,000	Per Incident

The Travelers Indemnity Company of CT	6607D013207	10/01/14-15	$2,882

GENERAL LIABILITY – CHILD DEVELOPMENT CENTER

General Liability Limit

$2,000,000	Aggregate
2,000,000	Products/Completed Operations Aggregate
1,000,000	Personal & Advertising Injury
1,000,000	Each Occurrence
300,000	Damage to Premises Rented to You
5,000	Medical Expense (excludes children in daycare program)

Abuse/Molestation Limit

2,000,000	Aggregate
1,000,000	Each Abuse or Molestation Offense

Hartford Life and Accident Insurance Company	02SR365272	10/01/14-15	$340

SPECIAL RISK ACCIDENT – CHILD DEVELOPMENT CENTER

Limits:

$ 5,000	Accidental Death Benefit
10,000	Accidental Dismemberment Benefit
35,000	Catastrophe Benefit
25,000	Accident Medical Expense Benefit
1,000	Dental Limit

Schedule 7.04

Conflicts - Trinity Health and NE-RHM

Consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Trinity Health and NE-RHM in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transactions contemplated hereby and thereby:

Roman Catholic Archdiocese of Hartford
Holy See, Roman Catholic Church
State of Connecticut Office of HealthCare Access
Office of the Attorney General of the State of Connecticut
Federal Trade Commission

Schedule 7.08(a)

Compliance with Laws - NE-RHM

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC is reviewing the letter and expects to appeal.

Schedule 7.09(a)

Medicare - Plans of Correction - NE-RHM

Saint Francis Hospital and Medical Center had its tri-annual Joint Commission survey on October 21-24, 2014. We are in process of submitting corrective action plans which are due by December 20, 2014 and January 4, 2014. A follow-up visit occurred on December 4, 2014 to validate compliance with certain Conditions of Participation and the Joint Commission concluded Saint Francis Hospital and Medical Center was in compliance. A follow up visit was conducted by the Joint Commission on June 22-23, 2015. Full compliance with all standards was identified with no further actions required.

The Department of Public conducted a CMS validation survey beginning November 24, 2014. The Department of Public Health identified Saint Francis Hospital and Medical Center was in full CMS compliance.

Mount Sinai Rehabilitation Hospital had its tri-annual Joint Commission survey on December 1st and 2nd of 2014. The report has been received, full compliance with CMS standards was identified and the evidence of Joint Commission standards compliance was submitted by the due dates of January 16, 2015 (45 day plan) and January 31, 2015 (60 day plan). Full compliance with Joint Commission standards was identified by the Joint Commission with acceptance of completed plans and data metrics on June 2, 2015.

Schedule 7.09(b)

Medicare/Medicaid Claims - NE-RHM

None.

Schedule 7.12

HIPAA - Breach Notifications - NE-RHM

Date of Occurrence	Description	Status
11/10/2014	Theft of camera at Access Center	A breach notification has not yet been made regarding this occurrence, as Saint Francis is still completing its internal investigation. Incident reported in the 2015 Annual Report to OCR.
10/24/2014	Inappropriate Access to PHI	Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR.
9/23/2014	Stolen Laptop	Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR.
12/27/2013	Paper records with certain patient information stolen from physician's vehicle	There have been two requests for information from the Office of Civil Rights regarding this occurrence and Saint Francis has responded to both requests. OCR has closed this matter. Refer to 6.14(a).

Schedule 8.08(a)

Insured Real Property

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

2. Parcel Two

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

3. Parcel Three

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

4. Parcel Four

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

5. Parcel Five

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

6. Parcel Six

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

7. Parcel Seven

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

8. Parcel Eight

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

9. Parcel Nine

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

10. Parcel Ten

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

11. Parcel Eleven

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

12. Parcel Twelve

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

13. Parcel Thirteen

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

14. Parcel Fourteen

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

15. Parcel Fifteen

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

16. Parcel Sixteen

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

17. Parcel Seventeen

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

18. <u>Parcel Eighteen</u>

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

NORTHERLY:	79 feet on East Main Street
EASTERLY:	136 feet on Second Piece;
SOUTHERLY:	on land now or formerly of The Church of the Immaculate Conception; and
WESTERLY:	136 feet on land now or formerly of The Church of the Immaculate Conception.

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

NORTHERLY:	28.00 feet, more or less, by East Main Street;
EASTERLY:	130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street;
SOUTHERLY:	20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and
WESTERLY:	136.00 feet by land of Philip Avery.

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

NORTHEASTERLY:	19.86 feet by East Main Street;
SOUTHEASTERLY:	136.00 feet by land now or formerly of Philip Veillette, et al;
NORTHEASTERLY:	again 99.25 feet by land now or formerly of Philip Veillette, et
SOUTHEASTERLY:	al; again 43 feet, more or less, by Baldwin Street, fka Mill
SOUTHEASTERLY:	Street; again
SOUTHWESTERLY:	by Baldwin Street, fka Mill Street;
NORTHWESTERLY:	251.25 feet by land now or formerly of the Church of the Immaculate Conception; 136.68 feet by land now or formerly of the Church of the Immaculate Conception.

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

Office of the President
Chad W. Wable, FACHE

Saint Mary's
HEALTH SYSTEM

September 18, 2015

JANEANNE LUBIN-SZAFRANSKI
SAINT FRANCIS CARE, INC.
114 WOODLAND ST
HARTFORD, CT 06105

TRINITY HEALTH CORPORATION
20555 VICTOR PARKWAY
LIVONIA, MI 48152

RE: Supplemental Disclosure Letter

Dear Ms. Lubin-Szafranski:

In connection with the Transfer Agreement, dated September 18, 2015, by and among Saint Francis Care, Inc. ("Saint Francis"), Trinity Health Corporation ("Trinity"), Saint Mary's Health System, Inc., and Saint Mary's Hospital, Inc. ("Saint Mary's") (collectively, the "Parties"), Saint Mary's has requested to make several supplemental disclosures herein and Trinity Health and Saint Francis have agreed thereto. By signing below, the Parties agree the below disclosures are valid disclosures to the Transfer Agreement and have the same force and effect as the Transfer Agreement Disclosure Schedules. Based on the foregoing, Saint Mary's makes the following supplemental disclosures:

6.15

[redacted]

6.19:

Initial Breach Report, dated February 28, 2014, individual patient - unauthorized access/disclosure

Initial Breach Report, dated February 28, 2014, five patients affected - mail incorrectly addressed

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(f):

Policies and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(k):

Saint Mary's Hospital has a number of individual non-competition, non-disclosure and severance payment agreements in effect with a number of Officers and Executives of Saint Mary's Hospital. The Agreements, and certain amendments, are generally dated from 2008 to 2014. The severance payment obligations vary by agreement and often are measured based on years of service at the time of termination with maximum dollar amount limits. However, because the individual payments by Saint Mary's Hospital are incurred for employment terminations which occur with or without cause, and because the agreements contain required terminated employee release of claims provisions for the payments to occur, it appears likely that Section 409A compliance issues will therefore exist. Such Agreements may be viewed by the IRS as deferred compensation agreements in substance, and because of the required releases of claims, as well as the total amounts to be paid by Saint Mary's Hospital, IRS Notices 2010-6 and 2010-80 may provide relief for any desired amendments to be implemented for purposes of complying with Section 409A, and so as to legally avoid potential IRS penalties, individual income tax liabilities, interest and non-payment penalties.

Very truly yours,

Dated: 9-18-15, 2015

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____
Name: Chad W. Wible, FACHE
Title: Chief Executive Officer

Dated: 9-18-15, 2015

TRINITY HEALTH CORPORATION

By: _____
Name:
Title:

Dated: 9-18-15, 2015

SAINT FRANCIS CARE, INC.

By: _____
Name:
Title:

Dated: 9-18-15, 2015

TRINITY HEALTH CORPORATION

By: _____
Name:
Title:

Dated: 9-18-15, 2015

SAINT FRANCIS CARE, INC.

By: _____
Name:
Title:

CLOSING DISCLOSURE SCHEDULE

This Closing Disclosure Schedule is being delivered in anticipation of Closing pursuant to Section 5.01 the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Trinity Health – New England, Inc. (f/k/a Saint Francis Care, Inc.), a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**).

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A _____ Knowledge of Saint Mary's
Schedule 1B _____ Knowledge of NE-RHM
Schedule 1C _____ Knowledge of Trinity Health
Schedule 2.01 _____ SMH Board Members
Schedule 3.02 _____ NE-RHM Board of Directors - Saint Mary's Members
Schedule 6.04 _____ Conflicts/Consents
Schedule 6.05 _____ Organizational Chart
Schedule 6.07 _____ Undisclosed Liabilities
Schedule 6.08 _____ Absence of Certain Changes, Events, Conditions
Schedule 6.09 _____ Material Contracts
Schedule 6.09(c) _____ Material Contracts - Validity
Schedule 6.10 _____ Permitted Encumbrances
Schedule 6.11 _____ Condition and Sufficiency of the Saint Mary's Assets
Schedule 6.12(a) _____ Owned Real Property
Schedule 6.12(b) _____ Leased Real Property
Schedule 6.14(a) _____ Legal Proceedings
Schedule 6.14(b) _____ Governmental Orders
Schedule 6.15(a) _____ Compliance With Laws
Schedule 6.16(a) _____ Medicare - Plans of Correction
Schedule 6.16(b) _____ Medicare - Claims
Schedule 6.16(d) _____ Medicare - Accreditation Surveys/Deficiency List
Schedule 6.19 _____ HIPAA - Breach Notifications
Schedule 6.20 _____ Affiliate Transactions
Schedule 6.21(e) _____ Environmental
Schedule 6.22(a) _____ Employee Benefit Plans
Schedule 6.22(b) _____ Benefit Plans - Compliance
Schedule 6.22(c) _____ Employee Pension Benefit Plan Liability
Schedule 6.22(d) _____ Multiemployer Plan Liability
Schedule 6.22(e) _____ Church Plans
Schedule 6.22(f) _____ Employee Welfare Benefit Plans
Schedule 6.22(g) _____ Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans

Schedule 6.23 _____ Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

Schedule 1A

Knowledge of Saint Mary's

No updates.

Schedule 1B

Knowledge of NE-RHM

1. Christopher M. Dadlez, President and CEO
2. David Bittner, Senior Vice President and CFO
3. Janeanne C. Lubin-Szafranski, Senior Vice President and General Counsel
4. Jennifer S. Schneider, Vice President of Finance

Schedule 1C

Knowledge of Trinity Health

No updates.

Schedule 2.01

SMH Board Members

Directors and Officers

- Mengacci, Esq., Joseph
- Pugh, Richard
- Wable, Chad
- Mattie, Angela
- Roscoe, Robert

Directors

- Albert, Eric
- Albini, M.D., S. Mark
- Bachhuber, Theresa M.
- Ford, Father Christopher
- Gumbardo, M.D., Robert
- Richi, M.D., Aziz
- Rodriguez, Felix
- Roer, M.D., David
- Sullivan, Esq., Christine
- Summa, Esq., Kara

Schedule 3.02

Board of Directors of NE-RHM - Saint Mary's Members

Notwithstanding the provisions of the Transfer Agreement, the Parties hereto agree that the following individuals will be added to the Board of Directors of NE-RHM effective as of September 1, 2016:

Garret Casey, Jr.

Stephen R. Griffin, Esq.

Schedule 6.04

Conflicts/Consents

(a) No updates.

(b) No updates.

(c)(i) No updates.

(1) Waterbury Hospital, as member of the Harold Leever Regional Cancer Center, Inc., provided consent in September 2015. Waterbury Hospital and SMH recently filed a CON modification in anticipation of the transaction contemplated in the Transfer Agreement.

(2) NVRA consent provided to NE-RHM and Trinity Health

(3) Notice to DSS required within 35 days post-closing

(4) Craneware consent letter sent out. Awaiting receipt

(5) Notice letter to McKesson provided to NE-RHM, Trinity Health

(6)

a. Consent of Archdiocese provided to NE-RHM, Trinity Health.
b. Consent of Holy See, Roman Catholic Church provided to NE-RHM, Trinity Health
c. OHCA approval received and provided to all parties
d. Notice provided to Connecticut Attorney General
e. FTC did not provide comment

(7) Upon further review, consent of Diagnostic Imaging of Southbury, LLC is not required.

(8) Per Section 10.01 of the Indenture of Lease by and between Park West, LLC and Saint Mary's Hospital, Park West, LLC required consent to transfer the Indenture of Lease. Proof of Park West, LLC's consent to the transfer has been provided to NE-RHM and Trinity Health.

(9) Per Section 21(a) of the Lease by and between RPH Highland LLC and Saint Mary's Hospital, RPG Highland LLC required consent to assign the Lease. Proof of RPH Highland LLC's consent to the assignment has been provided to NE-RHM and Trinity Health.

(c)(ii) No updates.

(c)(iii) No updates.

(c)(iv) No updates.

(c)(v) Pursuant to Section 18.d. of the Master Service Agreement, dated January 5, 2009, by and between SMH and Connecticut Children's Medical Center ("CCMC"), CCMC may terminate the Master Service Agreement by providing written notice to SMH upon a Change of Control. Change of Control includes a change in the membership of SMH. SMH and CCMC remain on good terms and CCMC is not terminating the agreement.

(d) No updates.

Schedule 6.05

Organizational Chart

No updates.

Schedule 6.07

Undisclosed Liabilities

Webster Loan to be paid on August 1, 2016 and all necessary releases filed thereafter.

Schedule 6.08

Absence of Certain Changes, Events, Conditions

Schedule 6.08 is limited to changes, events, conditions from Balance Sheet Date (6/30/2015) until Signature Date (9/18/15) and thus no update is required

Schedule 6.09

Material Contracts

(i) Each Contract involving aggregate consideration in excess of $100,000

See attached.

(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000

1. Purchase and Sale Agreement by and between Peter Greco, M.D., Thomas Greco, M.D., and Saint Mary's Health System, Inc., for the Units 3-G and 3-F in the Medical Office Building located at 133 Scovill Street in Waterbury, CT.

(iii) All Contracts with any Governmental Authority

No updates.

(iv) Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement

No updates.

(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand

No updates.

(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party

No updates.

(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000

No updates.

SAINT MARY'S HOSPITAL ATTACHMENT TO CLOSING SCHEDULE 6.09(a)(i)

CONTRACT NUMBER	VENDOR OTHER PARTY
1001.1319C	Yale University School of Medicine
1001.1323C	Press Ganey
1001.1326E	PAC Planning Services, LLC
1002.1328C	Michael Malinics, MD
1002.1330C	Mary L. Aquavia, MD
1001.1341E	NVLM, Inc
1001.1351C	Berkeley Research Group (BRG)
1002.1354C	Pruner, Joseph MD
1001.1355C	Surgical Monitoring Services, Inc. d/b/a Sentient
1002.1358C	Ghisa, MD Adriana
1002.1368C	Nicolescu, Mirela MD
1002.1372C	1389 West Main Street, Suite 224, Waterbury CT
1002.1370C	Gniadek, Thomas MD
1002.1371C	Gniadek, Thomas MD Asset Purchase Agreement
1001.1381C	H2C (Hammond)
1002.1382C	Kett, Kevin MD
1002.1383C	Chang, MD Yueming
1001.1385C	RelayHealth
1002.1389C	United Health Care
1001.1401C	Atrion Networking Corporation
1001.1409C	Medtronic, Inc.
1002.1410C	Singanamala, MD Santhi
1002.1417C	Patel, MD Kush

1002.1416C	Rosado, MD Ana
1002.1418C	Cheema, Rabia
1002.1420C	1389 West Main Street, Suite 224, Waterbury CT 06708
1002.1421C	Shetty, Shopa MD
1002.1423C	Gnanaraj, Joseph MD

UPDATE TO SCHEDULE 6.09(a)(i) AS REFLECTED IN INITIAL DISCLOSURE SCHEDULES

MASTER COMMERCIAL CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1002C	Saint Mary's Hospital	Geonetric Technology
1001.1007E	Saint Mary's Hospital	McKesson Corporation
1001.1008E	Saint Mary's Hospital	McKesson Corporation
1001.1009E	Saint Mary's Hospital	McKesson Corporation
1001.1012C	Saint Mary's Hospital	McKesson Corporation
1001.1016C	Saint Mary's Hospital	Medtronic, Inc.
1001.1017C	Saint Mary's Hospital	Medtronic, Inc.
1001.1019C	Saint Mary's Hospital	Quinnipiac University
1001.1024E	Saint Mary's Hospital	Nuance Powerscribe
1001.1025E	Saint Mary's Hospital	Naugatuck Valley Community College
1001.1050C	Saint Mary's Hospital	RelayHealth
1001.1053C	Saint Mary's Hospital	RelayHealth
1001.1054C	Saint Mary's Hospital	Connecticut Hospital Association
1001.1060C	Saint Mary's Hospital	Roche Diagnostics Corporation
1001.1063E	Saint Mary's Hospital	Nuance Communications, Inc.
1001.1064E	Saint Mary's Hospital	McKesson Corporation
1001.1065C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1071C	Saint Mary's Hospital	Leidos Health LLC
1001.1085C	Saint Mary's Hospital	JVK Operations
1001.1092C	Saint Mary's Hospital	WB Mason
1001.1099C	Saint Mary's Physician Partners, LLC	Naugatuck Valley Women's Health Specialists, PC
1001.1100E	Saint Mary's Hospital	Wellsoft Corporation
1001.1120C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1121C	Saint Mary's Hospital	Allscripts Healthcare, LLC
1001.1160C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.1165C	Saint Mary's Hospital	Kronos
1001.1168C	Saint Mary's Hospital	Siemens Healthcare Diagnostics Inc.
1001.1171C	Saint Mary's Hospital	Grainger Industrial Supply
1001.1173C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.1177C	Saint Mary's Hospital	Truven Health
1001.1178C	Saint Mary's Hospital	Spendadvisor
1001.1185C	Saint Mary's Hospital	Universal Background Screening
1001.1189C	Saint Mary's Hospital	Intuitive Surgical, Inc.

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1191C	Saint Mary's Hospital	Beckman Coulter
1001.1193C	Saint Mary's Hospital	Draeger Medical, Inc.
1001.1204C	Saint Mary's Hospital	Cross Country Staffing
1001.1221C	Saint Mary's Hospital	Bard Peripheral Vascular, Inc.
1001.1225C	Saint Mary's Hospital	NVMRI
1001.1226C	Saint Mary's Hospital	Edwards Lifesciences LLC
1001.1237C	Saint Mary's Hospital	Covidien Sales, LLC
1001.1248C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1250C	Saint Mary's Hospital	St. Jude Medical
1001.1274C	Saint Mary's Hospital	PMA Management Corp. of New England
1001.1275C	Saint Mary's Hospital	Neuro Enterprises, LLC
1001.1286C	Saint Mary's Hospital	Baxter Healthcare Corporation
1001.190C	Saint Mary's Hospital	St Jude Medical US Division
1001.210C	Saint Mary's Hospital	Craneware, Inc.
1001.216C	Saint Mary's Hospital	University of Connecticut School of Medicine
1001.219C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.228C	Saint Mary's Hospital	Naugatuck Valley Lawn Maintenance, Inc.
1001.235E	Saint Mary's Hospital	School Readiness Grant Program
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.287C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.304E	Saint Mary's Hospital	Stryker
1001.332C	Saint Mary's Hospital	Heart Center of Greater Waterbury, Inc.
1001.354E	Saint Mary's Hospital	Sodexho Operations, LLC
1001.367E	Saint Mary's Hospital	Yale University School of Medicine
1001.393C	Saint Mary's Hospital	3M Health Care Service Center
1001.411C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.420C	Saint Mary's Hospital	Western Connecticut State University
1001.427C	Saint Mary's Hospital	Sodexho Operations, LLC
1001.430C	Saint Mary's Hospital	Yale University School of Medicine
1001.433C	Saint Mary's Hospital	Yale University School of Medicine
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.468C	Saint Mary's Hospital	University of Connecticut, Department of Allied Health Sciences
1001.469C	Saint Mary's Hospital	University of Connecticut School of Nursing
1001.474C	Saint Mary's Hospital	Haemonetics Corporation
1001.47C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.482C	Saint Mary's Hospital	Department of Public Health
1001.489C	Saint Mary's Hospital	Gateway Community College

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.490C	Saint Mary's Hospital & Health System	Santa Buckley Energy, Inc.
1001.495E	Saint Mary's Hospital	GE Healthcare
1001.519C	Saint Mary's Hospital	University of Connecticut School of Social Work
1001.521C	Saint Mary's Hospital	Department of Social Services
1001.525C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.541C	Saint Mary's Hospital	Waterbury Department of Education
1001.54C	Saint Mary's Hospital	3M Health Care Service Center
1001.590C	Saint Mary's Hospital	bioMerieux, Inc.
1001.592C	Saint Mary's Hospital	American National Red Cross
1001.603C	Saint Mary's Hospital	Unitex Textile Rental Services
1001.608C	Saint Mary's Hospital	City-Wide Delivery Service, Inc.
1001.632C	Saint Mary's Hospital	McKesson Health Solutions, LLC
1001.633E	Saint Mary's Hospital	Otis Elevator Company
1001.653C	Saint Mary's Hospital	Siemens Industry, Inc.
1001.668C	Saint Mary's Hospital	Yale University School of Medicine
1001.676E	Saint Mary's Hospital	SkillSurvey
1001.679C	Saint Mary's Hospital	3M Health Care Service Center
1001.681C	Heart Center of Greater Waterbury	University of Connecticut Health Center Department of Finance
1001.682C	Saint Mary's Hospital	Med3000, Inc.
1001.688C	Saint Mary's Hospital	Yale University School of Medicine
1001.691C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.694C	Saint Mary's Hospital	Healthstream, Inc.
1001.749C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.750C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.768C	Saint Mary's Health System	Axiom Group, LLC
1001.783C	Saint Mary's Hospital	Best Practices, Inc.
1001.786C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.787E	Saint Mary's Hospital	GE Medical Systems
1001.788C	Saint Mary's Hospital	Financial Health Strategies, Inc.
1001.811C	Saint Mary's Hospital	Department of Public Health
1001.814C	Saint Mary's Hospital	Executive Health Resources, Inc. (E.H.R.)
1001.820E	Saint Mary's Hospital	Dell
1001.8221C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.825E	Saint Mary's Hospital	Diagnostic Equipment Service Corporation (DESCO)
1001.829C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.840C	Saint Mary's Hospital	University of Connecticut School of Allied Health

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.852C	Saint Mary's Hospital	Bay State Anesthesia
1001.853C	Saint Mary's Hospital	Department of Public Health
1001.858C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.860C	Saint Mary's Hospital	Syntrac Cardinal Health
1001.861C	Saint Mary's Hospital	Sunquest Information Systems, Inc.
1001.866C	Saint Mary's Health System	VPNE Parking Solutions, LLC
1001.882C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.884C	Saint Mary's Hospital	Olympus America, Inc.
1001.886C	Saint Mary's Hospital	Telephone Nurse Triage - Kanagaratnam Jegathesan, MD
1001.890E	Saint Mary's Hospital	Corepoint
1001.891C	Saint Mary's Hospital	Advantage RN
1001.944C	Saint Mary's Hospital	RelayHealth
1001.950C	Saint Mary's Hospital	Xtend Healthcare, LLC
1001.962C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.979C	Saint Mary's Hospital	Yale University School of Medicine
1001.997C	Saint Mary's Health System, Inc.	McKesson Corporation
1002.1048C	Franklin Medical Group, P.C.	Nuance Communications, Inc.
1002.1090C	Franklin Medical Group, P.C.	Digestive Disease Center of CT, LLC
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1002.448C	Franklin Medical Group, P.C.	Department of Public Health
1002.530C	Franklin Medical Group, P.C.	Napiello, Virginia APRN
1002.888E	Franklin Medical Group, P.C.	Phoenix Internal Medicine Associates, LLC
1002.958C	Franklin Medical Group, P.C.	VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc.
1002.959C	Franklin Medical Group, P.C.	Thames Records Management
1002.967C	Franklin Medical Group, P.C.	City-Wide Delivery Service, Inc.
1002.974C	Franklin Medical Group, P.C.	Intuitive Surgical, Inc.
1010.966C	Saint Mary's Hospital	Healogics Wound Care & Hyperbaric Services, Inc.
1010.968C	Saint Mary's Hospital	Commerce Bank
1010.978C	Saint Mary's Hospital	Central Connecticut State University
1010.985C	Saint Mary's Hospital	Jackson & Coker Permanent, LLC

NON-PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.445C	Saint Mary's Hospital, Inc.	Union Square Southbury, LLC (Landlord)
2005.445C	Saint Mary's Hospital, Inc.	Associated Physicians of Southbury, P.C. (Subtenant)
2005.762C	Saint Mary's Hospital, Inc.	146 Highland Associates, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc.	1981 East Main Street, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc. (Sublandlord)	Inwelligent Healthcare, Inc. (Subtenant)
2007.104C	Saint Mary's Hospital, Inc.	Scovill Commons Partners, LLC (Landlord)
2007.1186E	Saint Mary's Hospital, Inc.	Subway Real Estate Corp. (Tenant)
2007.1227C	Saint Mary's Hospital, Inc.	Northwest CT Public Safety Communications Center Inc. (Tenant)
2007.245C	Saint Mary's Hospital Corporation	Spectrum Square, LLC (Landlord)
2007.273E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.285E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.509E	Saint Mary's Hospital Corporation	Scovill Commons Partners, LLC (Landlord)
2007.760C	Saint Mary's Hospital	JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord)
2007.761C	Saint Mary's Hospital	Park West, LLC (Landlord)
2007.765E APPRAISAL/OPINION - NOT REVIEWED	N/A	N/A
2013.1129C	Franklin Medical Group, P.C.	1177, LLC (Landlord)

PROVIDER CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1072C	Saint Mary's Hospital	Singanamala, Santhi MD
1001.1082C	Saint Mary's Hospital	Waterbury Pulmonary Associates, LLC
1001.1105C	Saint Mary's Hospital	Brittny Williams Howell, MD
1001.110C	Saint Mary's Hospital	Martinucci, Erica MD
1001.1176C	Saint Mary's Physician Partners, LLC	
1001.1216C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.1298C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.323E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.342C	Saint Mary's Hospital	Consultants In Pathology, PC
1001.37C	Saint Mary's Hospital	Rho, Mira MD
1001.39C	Saint Mary's Hospital	Roer, David MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.407C	Saint Mary's Hospital	Neurosurgery Orthopaedics & Spine Specialists PC
1001.783E	Saint Mary's Hospital	EmCare, Inc. AND EmCare, Inc.
1001.480C	Saint Mary's Hospital	Milford Anesthesia Associates, LLC
1001.543E	Saint Mary's Hospital	Koteles, Alicia MD
1001.547C	Saint Mary's Hospital	Raissi, Sina MD
1001.570C	Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership)	SurgiCenter Anesthesiologists, PC
1001.580C	Saint Mary's Hospital	Mayo Medical Laboratories
1001.593C	Saint Mary's Hospital	Zarif, Abdul MD
1001.68C	Saint Mary's Hospital	Zarif, Abdulmasih MD
1001.764C	Saint Mary's Hospital	Naugatuck Valley Women's Health Specialists, PC
1001.988E	Saint Mary's Hospital	Wellmore Behavioral Health
1002.1020C	Franklin Medical Group, P.C.	Monzurul Chowdhury, MD
1002.1031C	Franklin Medical Group, P.C.	Bechoi Saleib, MD
1002.1037C	Franklin Medical Group, P.C.	Anna Freitag, MD
1002.1051C	Franklin Medical Group, P.C.	Frank Longo, MD
1002.1067C	Franklin Medical Group, P.C.	Ken Matsuo
1002.1069C	Franklin Medical Group, P.C.	Joseph Bowen, MD
1002.1101C	Franklin Medical Group, P.C.	Marano, Albert
1002.1102C	Franklin Medical Group, P.C.	Lyall, Bhupinder
1002.1103C	Franklin Medical Group, P.C.	Feinberg, Michael
1002.1104C	Franklin Medical Group, P.C.	Kraus, Mark, MD
1002.1107C	Franklin Medical Group, P.C.	Anupama Paranandi, MD Infectious Disease
1002.1109C	Franklin Medical Group, P.C.	Sallie Carrington, DO
1002.1110C	Franklin Medical Group, P.C.	Preissler, MD Paul
1002.1112C	Franklin Medical Group, P.C.	Garsten, MD Joel
1002.1113C	Franklin Medical Group, P.C.	Burlison, MD Kathleen
1002.1117C	Franklin Medical Group, P.C.	Cohen, Matthew, MD
1002.113C	Franklin Medical Group, P.C.	Palesty, J Alexander MD
1002.116C	Franklin Medical Group, P.C.	Wetmore, Robert S MD, PC
1002.117C	Franklin Medical Group, P.C.	Sieling, Beth Ann MD
1002.118C	Franklin Medical Group, P.C.	Sookhan, Nicole MD
1002.11C	Franklin Medical Group, P.C.	Rosenhein, Brian DO
1002.1208C	Franklin Medical Group, P.C.	Giacomazzi, Peter, MD
1002.120C	Franklin Medical Group, P.C.	Galal, Magdy MD
1002.1238C	Franklin Medical Group, P.C.	Shetty, MD Shohan
1002.1242C	Franklin Medical Group, P.C.	Neamtu, MD Andreea

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.1268C	Franklin Medical Group, P.C.	Gork MD, Ahmet
1002.1269C	Franklin Medical Group, P.C.	Khan MD, Tasneem
1002.1270C	Franklin Medical Group, P.C.	Salerno MD, John
1002.1271C	Franklin Medical Group, P.C.	Polokoff MD, Ellen
1002.1272C	Franklin Medical Group, P.C.	Leal MD, Daniel
1002.1277C	Franklin Medical Group, P.C.	Medrano MD, Consuelito
1002.1278C	Franklin Medical Group, P.C.	Esemuede MD, Iyare
1002.1281C	Franklin Medical Group, P.C.	Thiruvengadam MD, Sudha
1002.12C	Franklin Medical Group, P.C.	Sheikh, Abdul Majeed MD
1002.1300C	Franklin Medical Group, P.C.	Carolyn O'Connor, MD
1002.1303C	Franklin Medical Group, P.C.	Greco, Thomas MD
1002.1304C	Franklin Medical Group, P.C.	Ann Marie Conti-Kelly, MD
1002.15C	Franklin Medical Group, P.C.	Te, Victorio Go MD
1002.18E	Franklin Medical Group, P.C.	Simms, Michael F MD
1002.20C	Franklin Medical Group, P.C.	Imam, Azhar MD
1002.22C	Franklin Medical Group, P.C.	Nawaz, Shah MD
1002.23C	Franklin Medical Group, P.C.	Alston, Shawnette MD
1002.25C	Franklin Medical Group, P.C.	Beri, Rohit MD
1002.26C	Franklin Medical Group, P.C.	Bogursky, Sondra MD
1002.299C	Franklin Medical Group, P.C.	Anthony, J Robert MD
1002.29C	Franklin Medical Group, P.C.	Colodner, Gregory MD
1002.34C	Franklin Medical Group, P.C.	Newell, Rebecca O MD
1002.36C	Franklin Medical Group, P.C.	Ouellette, Jason MD
1002.379C	Franklin Medical Group, P.C.	Chere, Mitch MD
1002.3C	Franklin Medical Group, P.C.	Ramos, Rey MD
1002.41C	Franklin Medical Group, P.C.	Talwalkar, Jaideep MD
1002.42C	Franklin Medical Group, P.C.	Vaezy, Ali MD
1002.432C	Franklin Medical Group, P.C.	Ndiaye, Mouhamed A MD
1002.457C	Franklin Medical Group, P.C.	Gega, Arjet MD
1002.493C	Franklin Medical Group, P.C.	Kelly, Paul MD
1002.501C	Franklin Medical Group, P.C.	Zhang, He MD
1002.503C	Franklin Medical Group, P.C.	Baba, Carolina Borz MD
1002.508C	Franklin Medical Group, P.C.	Rubenstein, Stephen MD
1002.513C	Franklin Medical Group, P.C.	Rovetto, Allyson MD
1002.515C	Franklin Medical Group, P.C.	Brenes, Laura C MD
1002.516C	Franklin Medical Group, P.C.	Zlotoff, Ronald A MD
1002.528C	Franklin Medical Group, P.C.	D'Souza, Bernard MD
1002.55C	Franklin Medical Group, P.C.	Almeida, Carlos MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.569C	Franklin Medical Group, P.C.	Richi, Maysoun MD
1002.56C	Franklin Medical Group, P.C.	Alvarez, Alexander J MD
1002.58C	Franklin Medical Group, P.C.	Testa, John MD
1002.59C	Franklin Medical Group, P.C.	Uberti, James G MD
1002.614C	Franklin Medical Group, P.C.	Richi, Aziz MD
1002.655C	Franklin Medical Group, P.C.	Quinn, Edmund
1002.685C	Franklin Medical Group, P.C.	Karen Kennedy
1002.69C	Franklin Medical Group, P.C.	Cardiology Associates of Waterbury, PC
1002.756C	Franklin Medical Group, P.C.	Zefirova, Julia MD
1002.758C	Franklin Medical Group, P.C.	Cumberland, Melisha MD
1002.817C	Franklin Medical Group, P.C.	Mario Perez
1002.827E	Franklin Medical Group, P.C.	Seli, Meltem MD
1002.848C	Franklin Medical Group, P.C.	Albajrami, Oltjon MD
1002.879C	Franklin Medical Group, P.C.	Ranjan, Saurabh MD
1002.887C	Franklin Medical Group, P.C.	El-Hennawy, Magdy Sayed MD
1002.915C	Franklin Medical Group, P.C.	Philip R. Corvo, MD
1002.93C	Franklin Medical Group, P.C.	Naugatuck Valley OBGYN PC
1002.943C	Franklin Medical Group, P.C.	Maria Dawe, MD
1002.961C	Franklin Medical Group, P.C.	Macaron, Shady Hafez MD
1002.972C	Franklin Medical Group, P.C.	Naugatuck Valley Women's Health Specialists, PC
1002.993C	Franklin Medical Group, P.C.	Aditi Mukherji, MD
1002.995C	Franklin Medical Group, P.C.	Rebecca Scandrett, MD
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center

PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.364C	Saint Mary's Hospital	Saint Mary's Hospital
2007.1285C	Saint Mary's Hospital	LJL Properties, LLC
2007.296C	Saint Mary's Hospital	West Main Medical, LLC, a Connecticut limited liability company, as Landlord
2008.534C	Primary Care Partners, P.C.	Greater Waterbury Primary Care Associates, P.C., as Tenant

Schedule 6.09(c)

Material Contracts - Validity

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

Schedule 6.10

Permitted Encumbrances

(1) Filing No. 0003104990 in favor of Wells Fargo Equipment Finance, Inc.

(2) Filing No. 0003013154 in favor of General Electric

Schedule 6.11

Condition and Sufficiency of the Saint Mary's Assets

No updates.

Schedule 6.12(a)

Owned Real Property

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

Schedule 6.12(b)

Leased Real Property

1. The property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, and which was subject to the lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006, as modified by the Lease Modification Agreement, dated January 1, 2009, is now owned by Saint Mary's Hospital, Inc.

Schedule 6.14(a)

Legal Proceedings

The following matters disclosed in the initial Disclosure Schedules have all been settled:

Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.

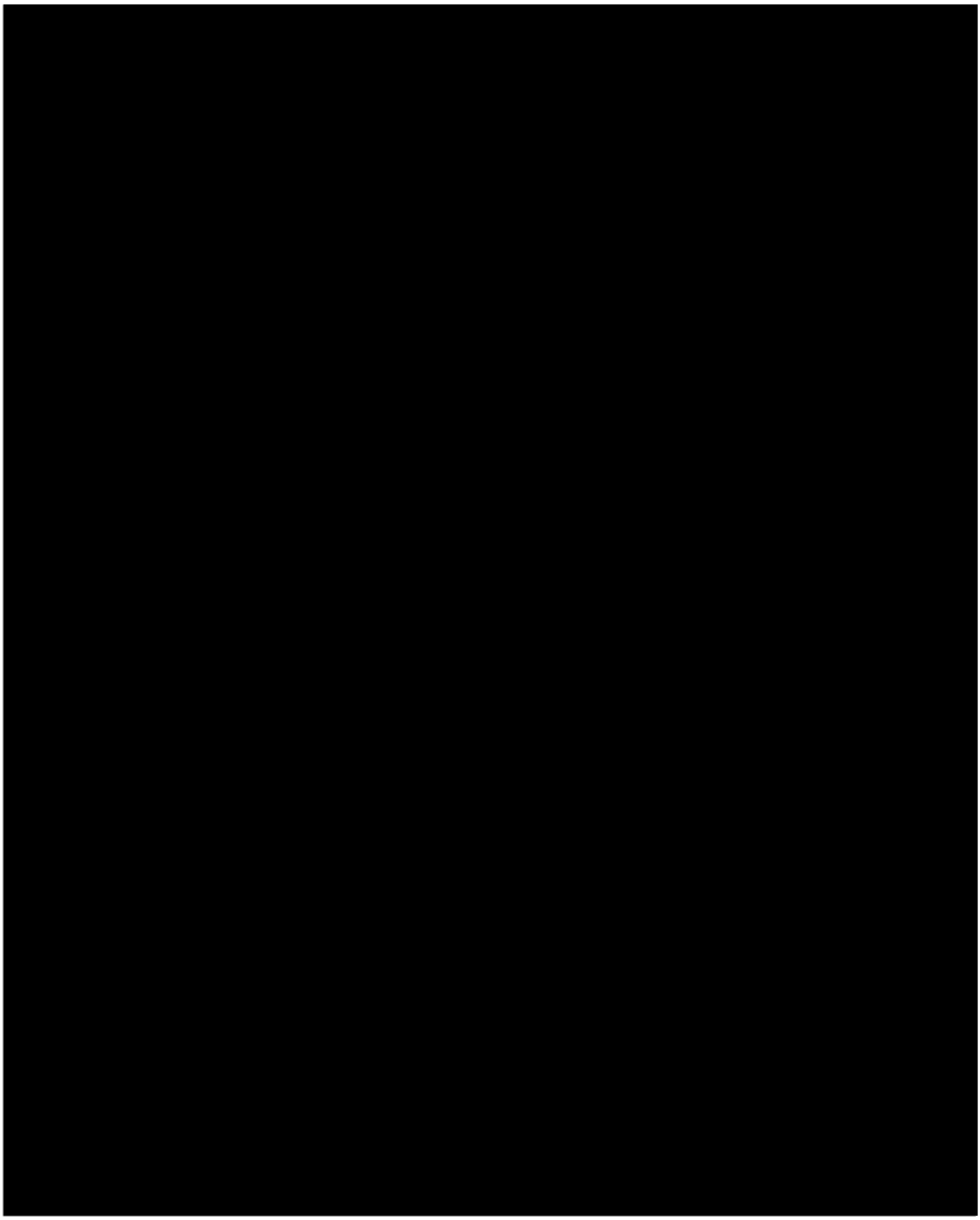
Schedule 6.14(b)

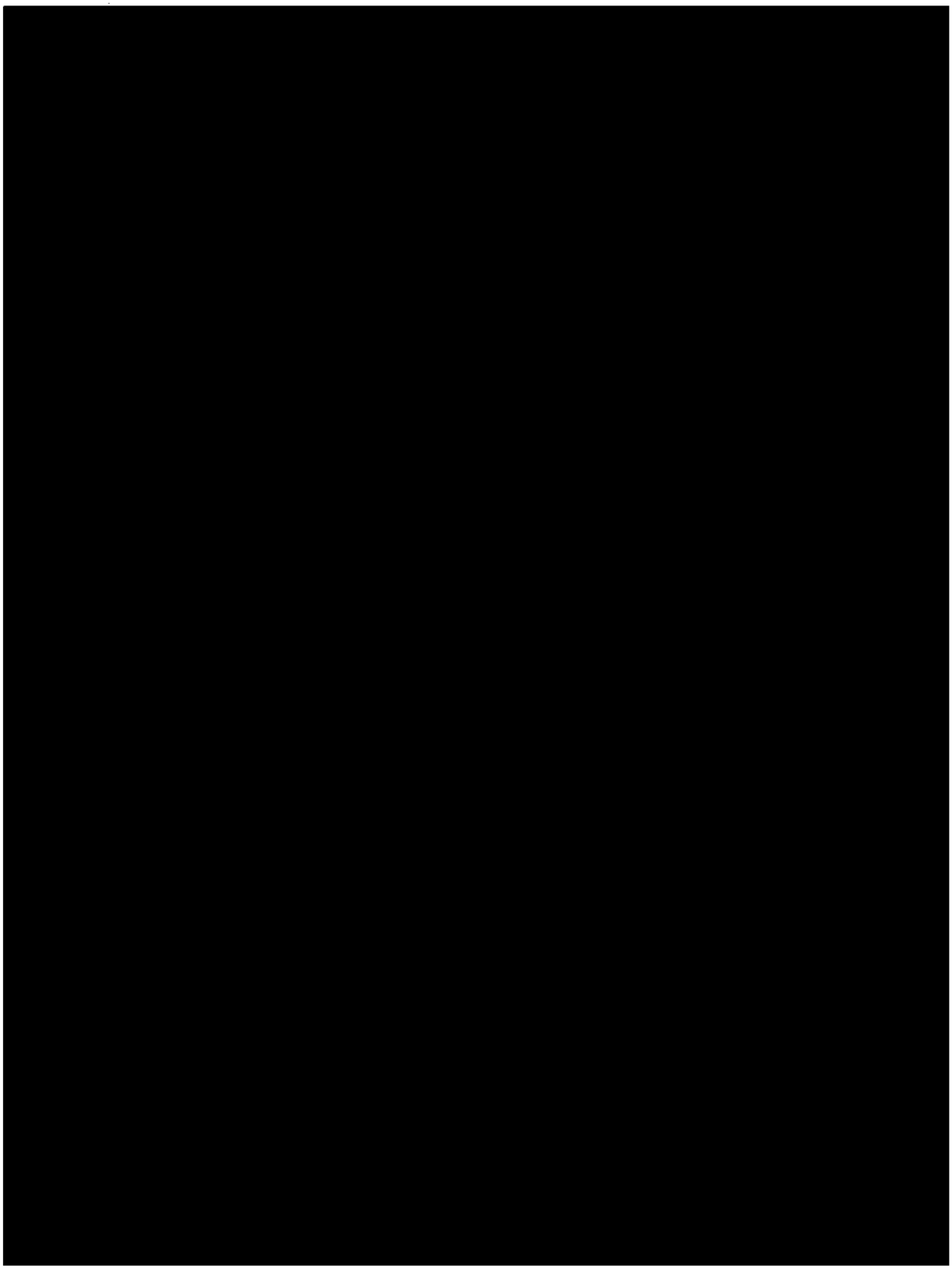
Governmental Orders

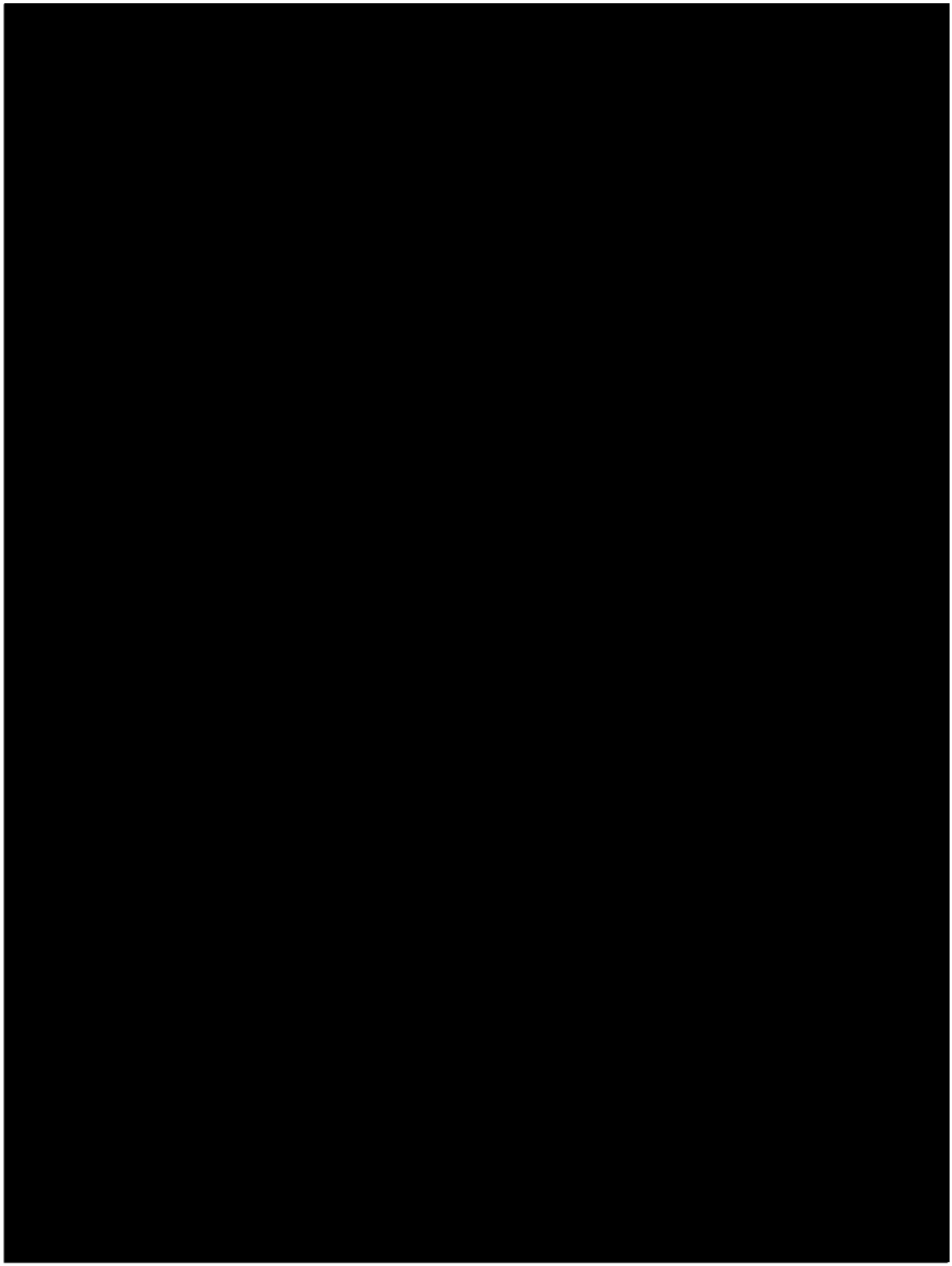
No updates.

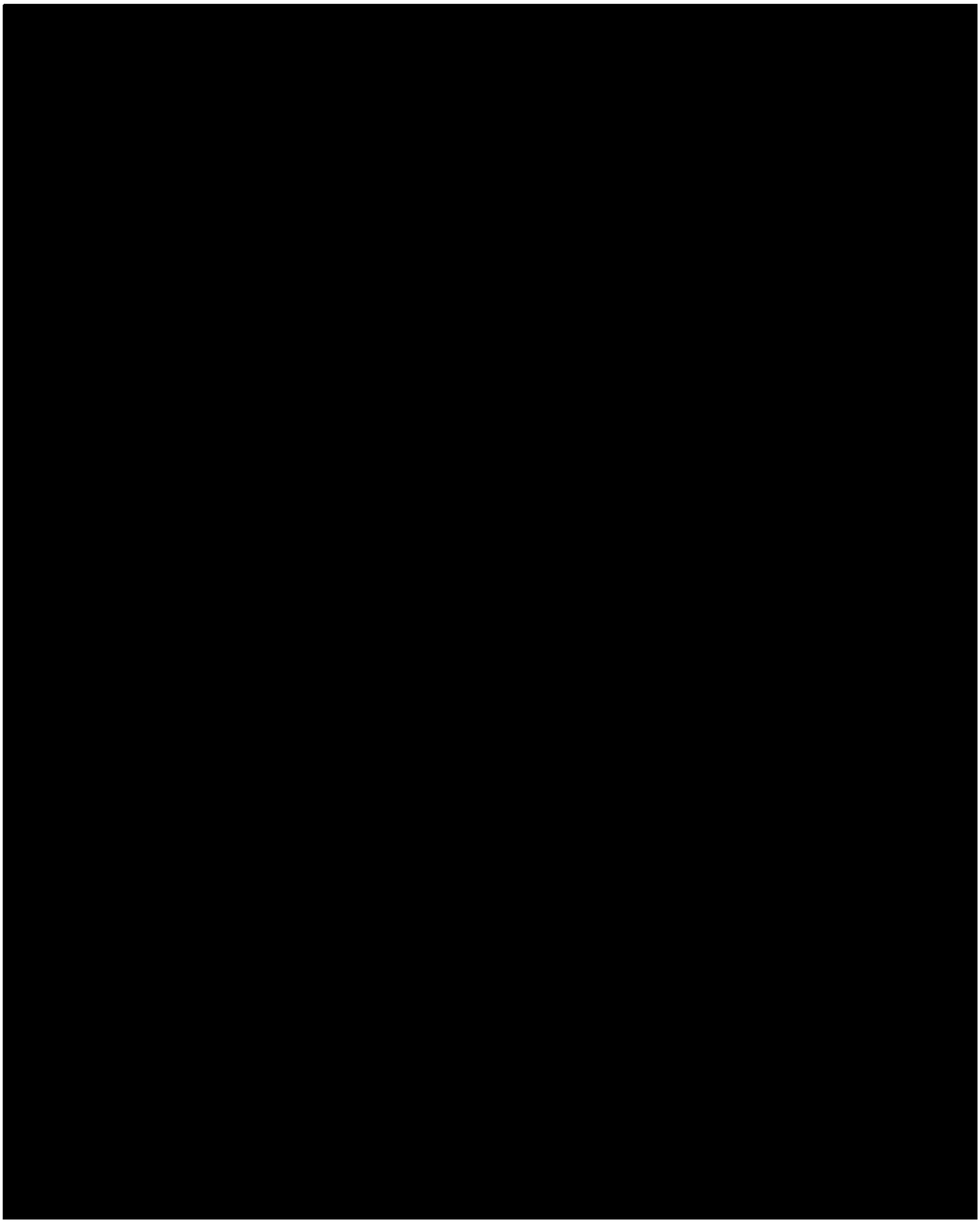
Schedule 6.15(a)

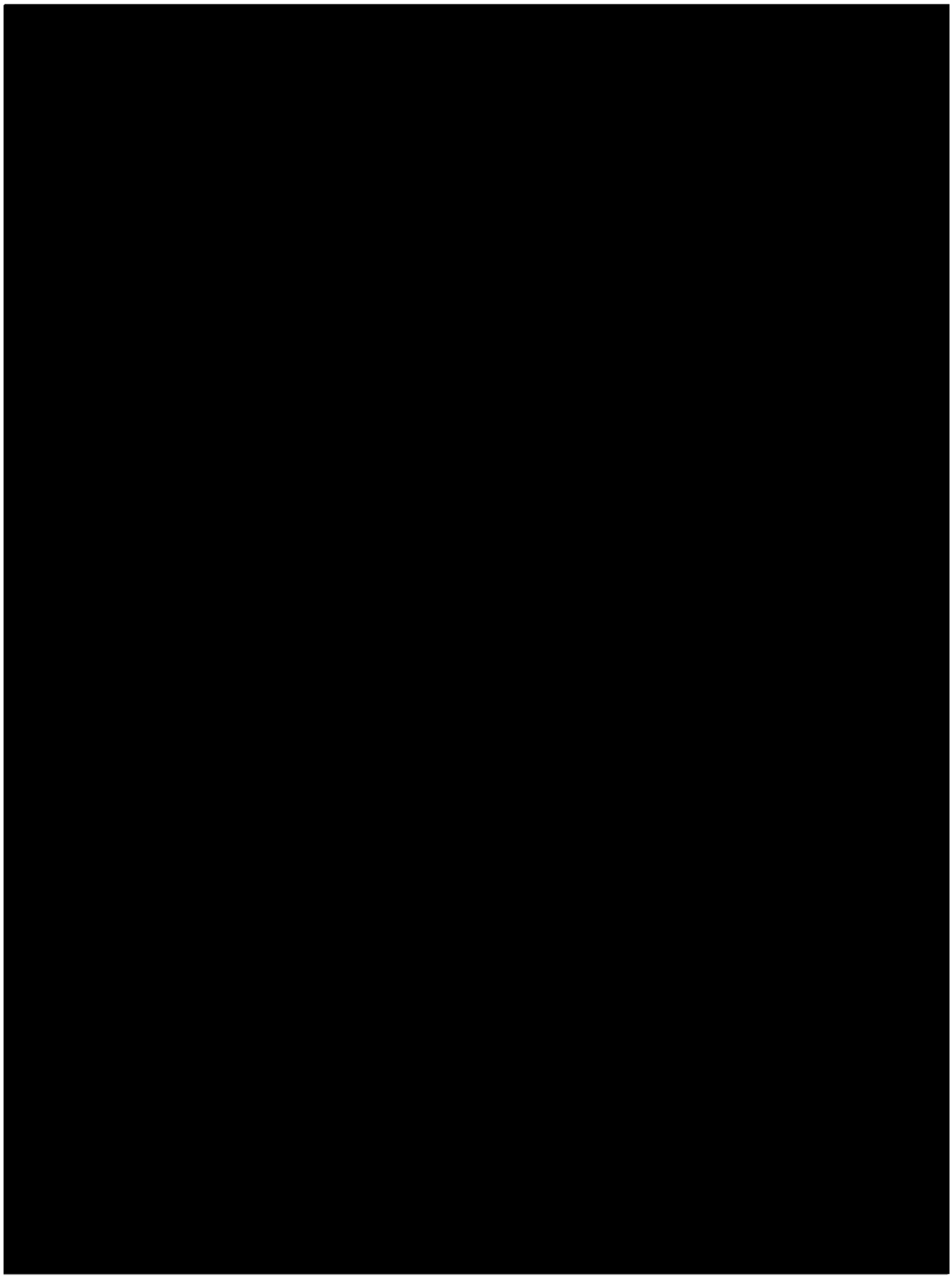
Compliance with Laws

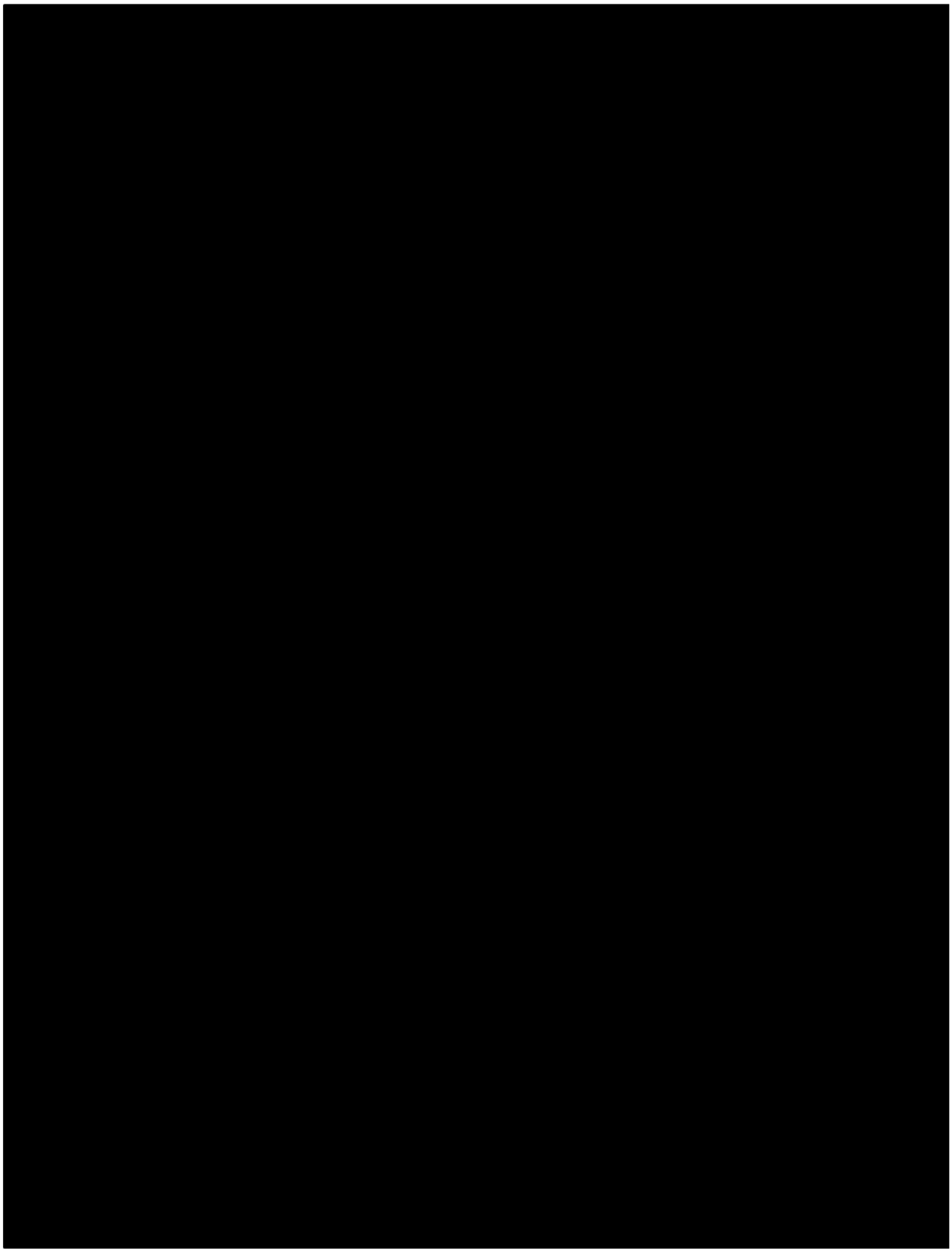


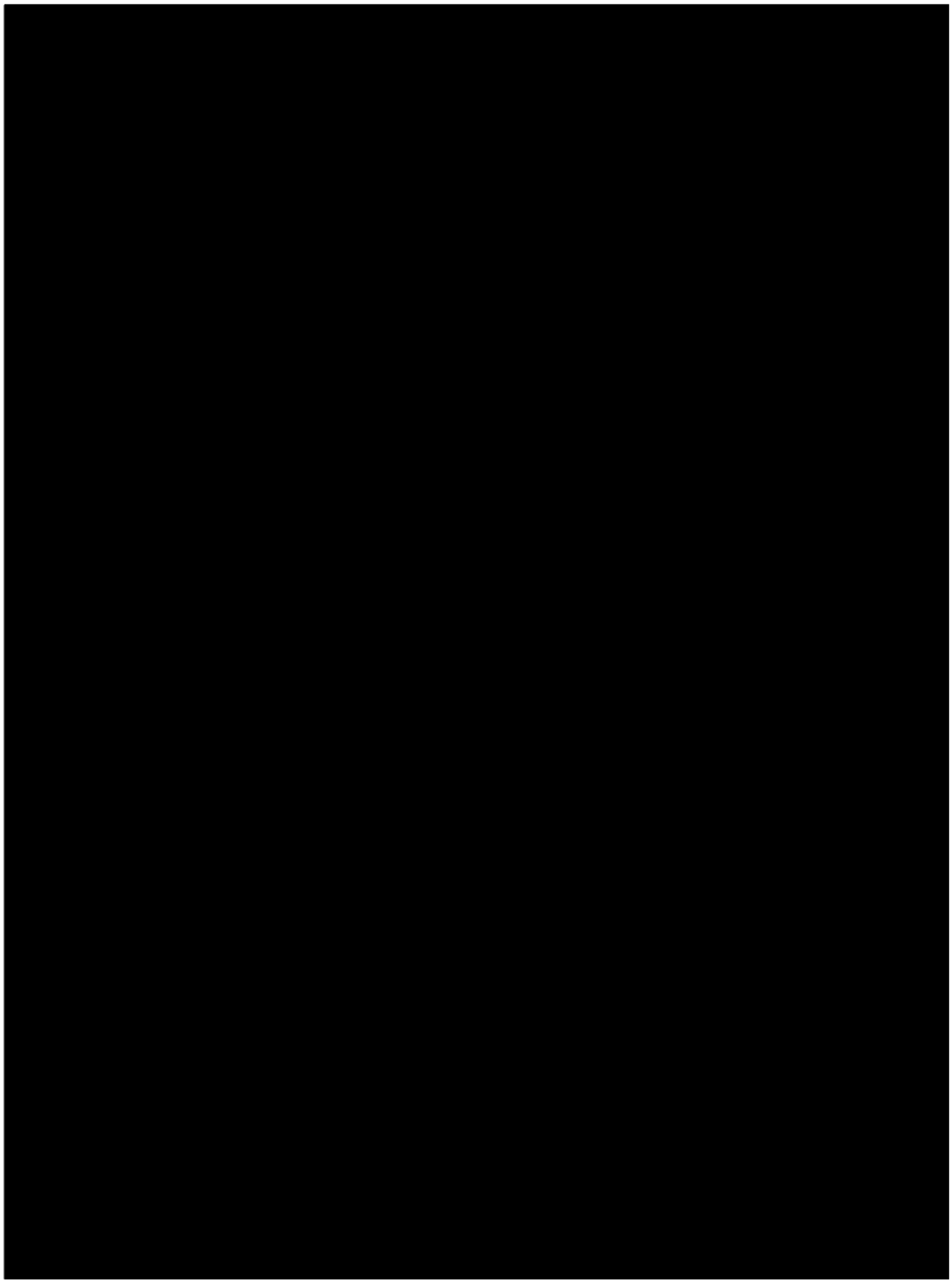


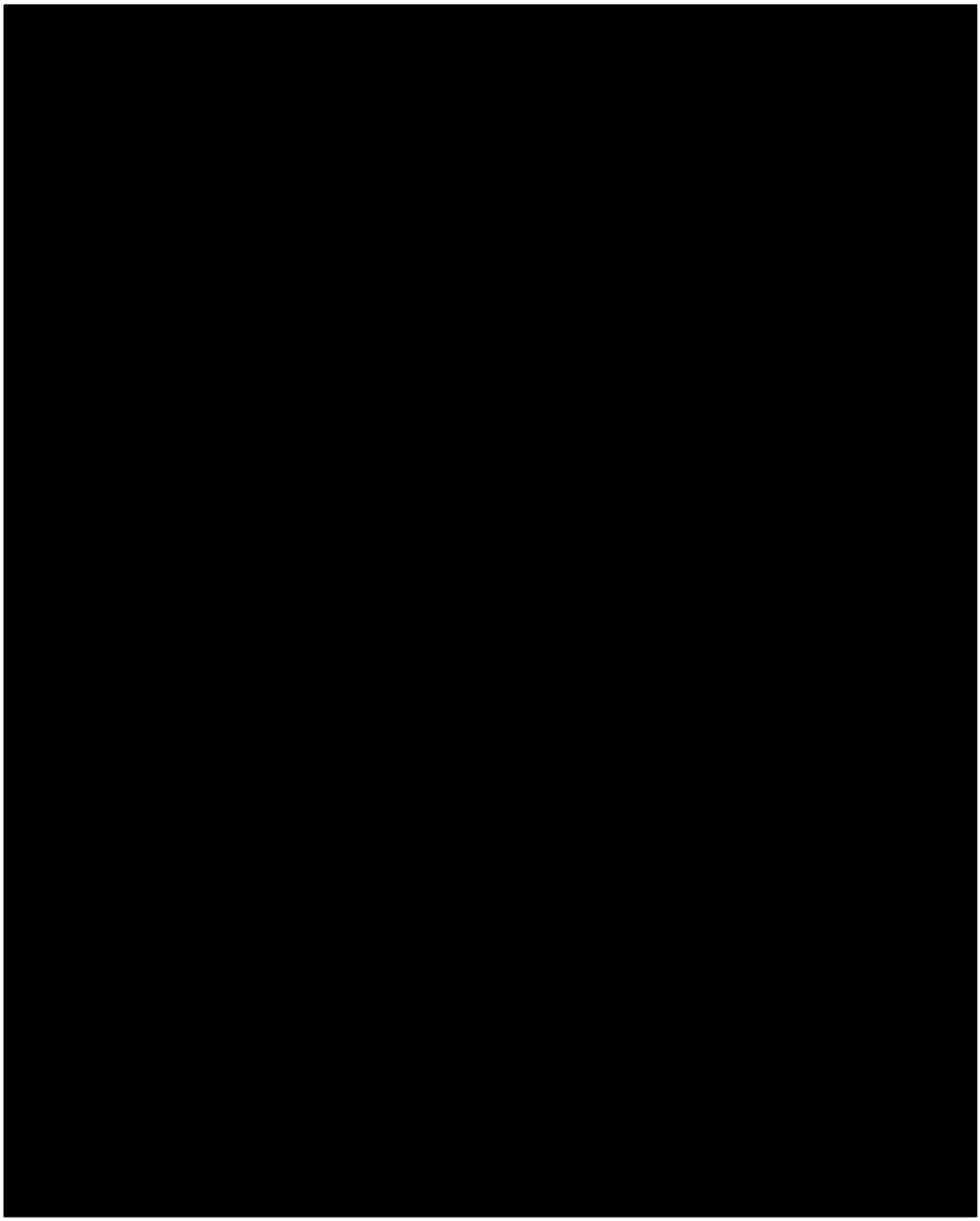


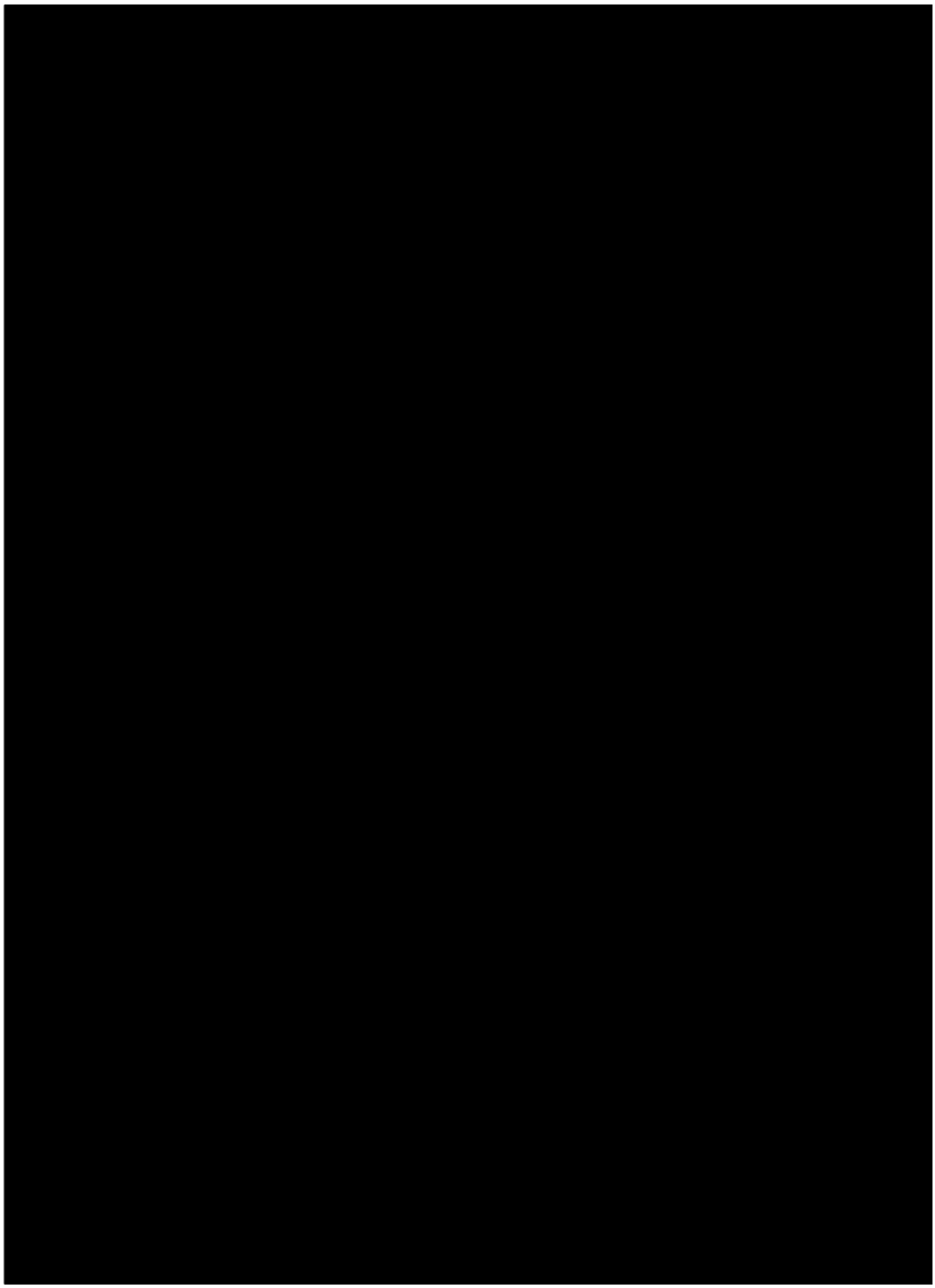


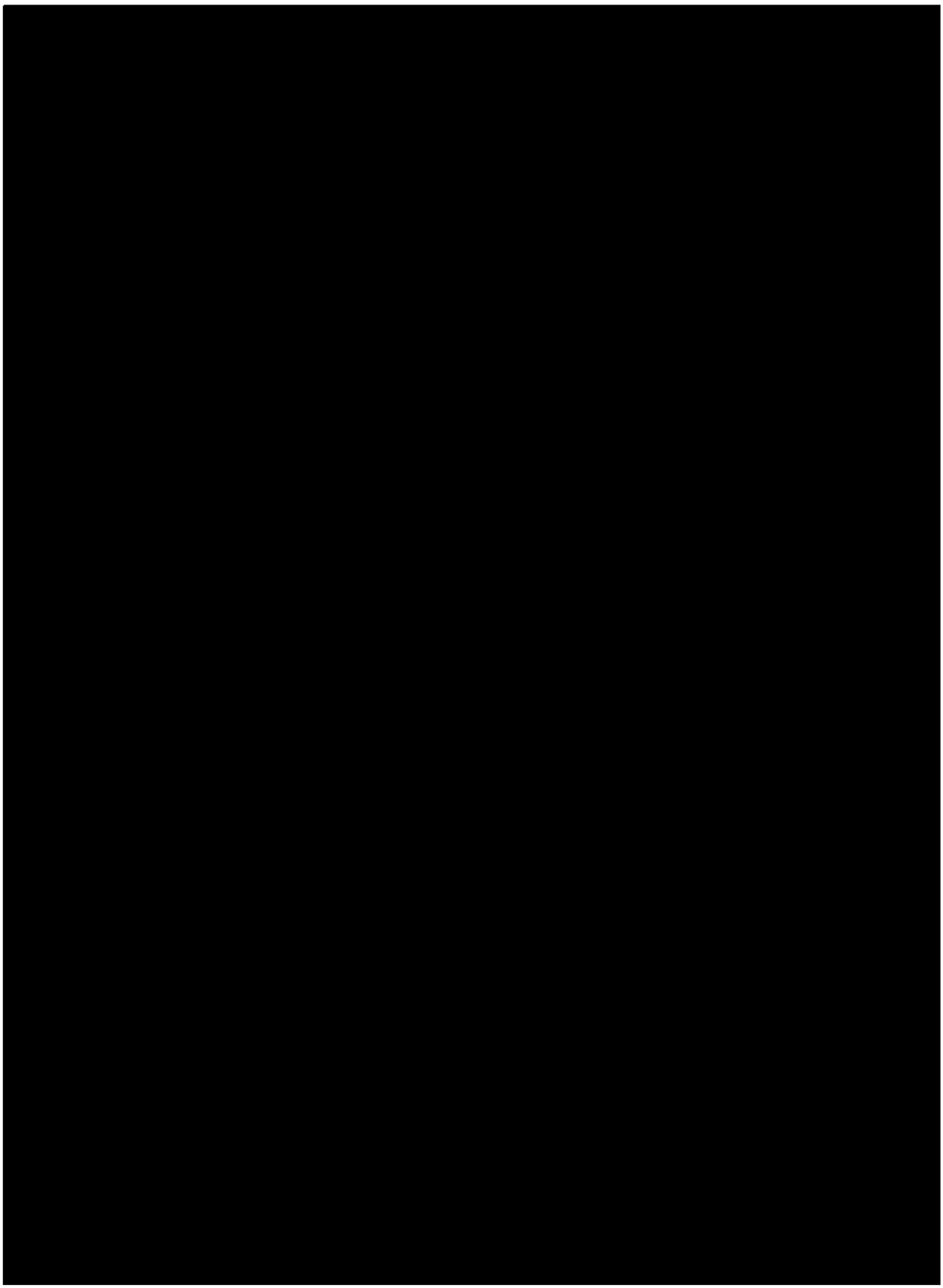












Schedule 6.16(a)

Medicare - Plans of Correction

No updates.

Schedule 6.16(b)

Medicare - Claims

- As of June 22, 2016, 454 Medicaid accounts were rebilled based on observation claims billed in excess of 24 hours. The total amount rebilled was $757,907.32. Notice of rebilling was placed in affected patient accounts. This matter is now closed.

- November 24, 2015 - Letter received from the State of Connecticut, Department of Social Services Office of Quality Assurance – Audit Division - Draft Results from FMG audit. A draft report was received covering DSS's audit of Medicaid claims paid to Franklin Medical Group during the period January 1, 2011 through December 31, 2013. The total of the proposed audit disallowances was $1,784,454. Additional documentation was provided and an exit interview was held. The final report was received on April 22, 2016. The overpayment due to DSS is $1,224,182. An appeal letter has been sent requesting a hearing.

Schedule 6.16(d)

Medicare - Accreditation Surveys/Deficiency Lists

No updates.

Schedule 6.19

HIPAA - Breach Notifications

- **February 10, 2016** - Saint Mary's reported a breach affecting approximately 33 individuals. On December 3, 2015, a contracted courier picked up a locked, secured bag containing 33 medical records from an outpatient center to bring to the hospital. During an intermediate stop, the courier's car, along with the bag containing the records, was stolen. The vehicle was recovered on December 7, 2015 but the records were not in the vehicle and were not recorded. Affected individuals were notified starting on December 4, 2015

Schedule 6.20

Affiliate Transactions

No updates.

Schedule 6.21(e)

Environmental

The following environmental reports came into the possession of Saint Mary's subsequent to the Signing Date:

1. Limited Asbestos Inspection - Kenny Building, 1st Floor Rooms K1-101 & K1-105, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated September 30, 2015

2. Limited Asbestos Inspection - Lawlor Building, Second Floor, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated October 12, 2015

3. Limited Suspect Asbestos Inspection and Bulk Sampling - O'Brien Building, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated January 22, 2016

4. Fire Pump Performance Inspection Report, performed by Mack Fire Protection, dated June 30, 2015

5. Certified Test, Adjust and Balance Report, performed by Air Balancing Service Co., dated June 22, 2015

6. Medical Gas System Inspection & Safety Survey, performed by Praxair Healthcare Services, dated March 10, 2016.

Schedule 6.22

Employee Benefit Matters

6.22(a)

1. Management Time Off Policy
2. Accrued Time-Off Benefits
3. HSA Plan
4. High Deductible Plan
5. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015.
6. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.
7. Wellness Plan

To the knowledge of Saint Mary's, with the exception of plan documents relating to the HSA and High Deductible plans, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health. The plan documents relating to the HSA and High Deductible plans have not been prepared to date.

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(c)

No updates.

6.22(d)

No updates.

6.22(e)

No updates.

6.22(f)

Policy and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(g)

1. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015

2. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.

6.22(h)

No updates.

6.22(k)

No amendments have been made to non-competition and severance agreements for purposes of complying with Section 409A.

Schedule 6.23

Employment Matters

No updates.

Schedule 6.24

Taxes

No updates.

Schedule 6.25

Insurance

[6.25(i) requires a true and complete list of all current insurance policies - this is unchanged since signature date and thus no updates are required. 6.25(ii) requires a list of all pending claims and the claims history related to SMH for the 10 year period prior to Signature Date and thus does not need to be updated. However, an updated list of pending claims has been provided to NE-RHM and Trinity Health.]

Schedule 7.04

Conflicts - Trinity Health and NE-RHM

No updates.

Schedule 7.08(a)

Compliance with Laws - NE-RHM

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC has appealed the Medicaid findings.

On June 29, 2016 Saint Francis Medical Group ("SFMG") concluded a retrospective review of claims billed to NGS, Medicare Administrative Contractor. SFMG determined that some of the critical care E&M services should have been billed as E&M subsequent care services. The result of the findings is that a refund is required for reimbursement received by SFMG for Inpatient Critical Care services that were not billed according to CMS instructions. These findings were first identified through an operational review in an attempt to identify possible opportunities for operational improvement as a part of SFHMC and SFMG's Integrity and Compliance Program ("ICP"). SFMG put corrective actions in place. The refund to the Medicare Program as a result of this review is $281,740 for the payments received as a result of the error in submitting E&M critical care when it should have been submitted as E&M subsequent care services to NGS Medicare for payment. Due to the time elapsed and the inability to file a corrected claim, SFMG returned the overpayment to Medicare for the aforementioned errors. SFMG is in the process of refunding $101,990 to the Medicaid program as a result of this review.

On May 18, 2016 SFHMC and SFMG received a civil investigative demand subpoena from the U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations, issued pursuant to the authority provided to the Inspector General under Public Law 95-452 in regards to services rendered by licensed independent practitioners. This is in document gathering phases at this time.

Schedule 7.09(a)

Medicare - Plans of Correction - NE-RHM

In addition to those matters originally set forth on Schedule 7.09(a) to the Transfer Agreement on the Signing Date:

The Department of Public Health conducted a Complaints; Adverse Events and CMS follow up survey beginning June 13, 2016. The Department of Public Health has not yet released any findings.

Schedule 7.09(b)

Medicare/Medicaid Claims - NE-RHM

No non-routine Medicare appeals

Saint Francis Hospital and Medical Center has several Inpatient and Outpatient Medicaid rate appeals and requests for hearings, with the first rate hearing scheduled for the fall of 2016.

Additionally, SFHMC has Department of Social Services and Department of Revenue Service Petitions for Declaratory Ruling on the Hospital Tax.

Schedule 7.12

HIPAA - Breach Notifications - NE-RHM

YEAR	Date of Occurrence	Title	Action
Reported to OCR 2/2015	10/24/2014	Inappropriate Access to PHI	Employee termination: Obtained information to locate ex-husband by looking at the record for his current significant other.
	9/23/2014	Stolen Laptop	Employee counseled: Medical Necessity Documentation saved to home computer in an effort to catch up on paperwork
	12/31/2013	Stolen ED Log	Employee counseled: Report to OCR January, 2014
Reported to OCR 2/2016	4/8/2015	USPS Damaged Package	Patient notified. Envelopes for mailing will be mylar.
	7/17/2015	Pulmonary office staff mailed lab results for several patients to one patient	Employee counselled and office staff re-educated
	10/26/2015	Adoptive/Birth Mother Demographics	Epic build to prevent sharing of demographic information between baby and birth mother.

Schedule 8.08(a)

Insured Real Property

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, October 28, 2016 12:17 PM
To: User, OHCA
Cc: Anthony, Robert J.
Subject: Submission for Condition #4 - 15-32045-CON Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England
Attachments: SMHCHNA_2016.pdf

Hello,

Per Condition # 4 of the Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England, ***Docket #: 15-32045-CON***, attached is the recently completed 2016 Community Health Needs Assessment (CHNA). A copy of the CHNA is publically available on the Saint Mary's website at https://www.stmh.org/about/chna/. The Implementation Strategy is currently in development and will be submitted once completed.

Feel free to contact me with any questions.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

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Saint Mary's Hospital
Community Health Needs Assessment

Saint Mary's
HOSPITAL
Exceptional care. Every patient. Every day.

Note: Approved and adopted by the Saint Mary's Hospital Board of Directors September 1, 2016

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Executive Summary

In collaboration with the Greater Waterbury Health Improvement Partnership, Saint Mary's Hospital led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2016. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This Community Health Needs Assessment serves as a compilation of the overall findings of each research component.

CHNA Data Components

- DataHaven Community Wellbeing Survey (2015)
- Healthy People 2020 Report (2014)
- The ALICE study of Financial Hardship Report (2012)
- US Center for Disease Control and Prevention
    - County Health Rankings and Roadmaps (2016)
- Saint Mary's Hospital Community Health Profile (2015)
- Hospital Implementation Plans (2013)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Obesity
- Tobacco Use
- Asthma
- Health Communications

Documentation

The final report of the CHNA was made public on September 30, 2016 and can be found on the Saint Mary's Hospital website (stmh.org). Paper copies are also available per request. The Saint Mary's Hospital Board of Directors approved the CHNA on September 1, 2016. An implementation plan for community health improvement activities will be created and available by February 15, 2017.

Introduction

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 2,100 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2016, Saint Mary's Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with The Greater Waterbury Health Improvement Partnership. The partnership consists of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Saint Mary's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs.

Community Health Needs Assessment Summary

Community Health Needs Assessments (CHNA) and implementation strategies are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. The CHNA and implementation strategies create an important opportunity to improve the health of communities by ensuring that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health.

Saint Mary's Hospital published its first federal mandated CHNA in 2013 in collaboration with contracted research and consulting firm, Holleran, and The Greater Waterbury Health Improvement Partnership. The 2016 assessment will serve as a starting point for data-based goals and strategies on how to address the needs that have been identified. The health needs acknowledged by the CHNA will be integrated into a three-year community outreach plan and implementation strategy to overcome the issues. By utilizing existing resources, strengthening partnerships and creating innovative programs on both the hospital campus and within the community, Saint Mary's Hospital hopes to make a positive impact on these identified needs.

Report on Progress since 2013 CHNA

Saint Mary's has made meaningful progress during this three-year CHNA cycle as we have opened two new urgent care centers and grown our primary care practices with over twenty new internal medicine providers. Saint Mary's now offers four urgent care centers throughout our service area offering convenient access and extended hours. We continue to offer nurse navigation services for emergency department patients, and for our cardiac program to provide education and coordinate post-acute services. We established the "Pump Club" for cardiac patients who needed additional services to attend rehab sessions and other services. Saint Mary's also established a heart rhythm program during this period, creating easier, local access to electrophysiology services that were previously not available in our community. Saint Mary's continues to support and collaborate with the Malta House of Care, which provides medical services to undocumented and indigent population. We continue to work closely with the Harold Leever Cancer Center to address smoking cessation in our community. We have hosted a series of farmers markets on the hospital campus using our community partner, Brass City Harvest. Through our work with the Greater Waterbury Health Improvement Partnership are working towards the creation of a Community Care Team to provide cross-organization case management for high utilization emergency department visitors.

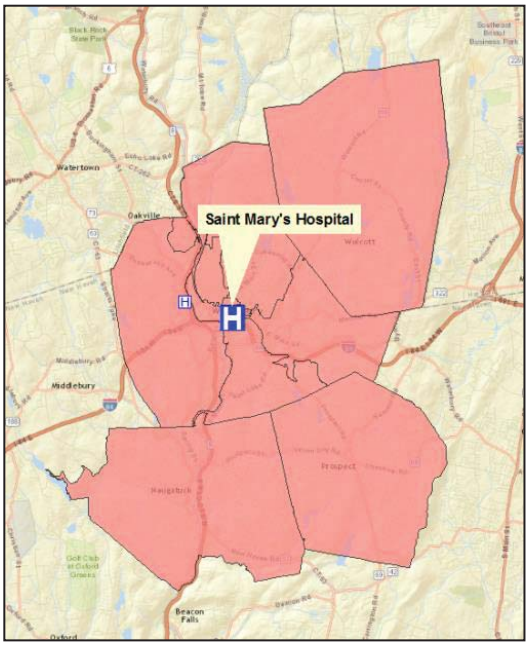
Since 2013 Saint Mary's has continued to work towards maintaining its existing programs while introducing new initiatives as appropriate. We have also continued to fully participate in the Greater Waterbury Health Improvement Partnership (GWHIP) which creates opportunities for collective impact, fosters greater collaboration community-wide, and helps make better use of resources by eliminating duplication of effort wherever possible. In August 2016 Saint Mary's joined Trinity Health, becoming a part of the Trinity Health – New England regional health ministry. Becoming part of a strong national and regional system will provide further opportunities to enhance our ability to meet the needs of our community.

Overview of Hospital Service Area and Facilities

Service Area

Saint Mary's total service area is comprised of 35 zip codes, which include the city of Waterbury and 17 surrounding towns. The primary service area which covers 9 US Census zip code tabulation areas (ZCTAs) includes Waterbury, Naugatuck, Prospect and Wolcott has a population of approximately 168,000. The secondary service area includes Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plantsville, Plymouth, Southbury, Thomaston, Watertown and Woodbury has a population of approximately 153,000.

Figure 1. Saint Mary's Primary Service Area Map



2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Population

The combined population for these communities is roughly 321,000 residents where the majority of Saint Mary's hospital patients live in the city of Waterbury which is particularly economically distressed. The median household income is $41,136, which is significantly less than the overall service area, which is approximately $70,000. The unemployment rate in the city of Waterbury in September 2015 was 10.7%. This is higher than the state of Connecticut unemployment rate of 6.6%. Approximately 31.6% of the population in Waterbury speaks a language other than English in the home. This is higher than the state of Connecticut where 20.8% of the population speaks a language other than English in the home. In addition, 24.2% of families in Waterbury have poverty status compared to 10.5% in Connecticut.

Central Waterbury has been designated a Medically Underserved Area (MUA) and Medically Underserved Population (MUP) by the health resources and services administration (HRSA). HRSA has also designated central Waterbury as a Health Professional Shortage Area (HPSA) for primary medical care, dental care and mental health. In Table 1. CHA Service Area Population Findings, there is a breakdown of population details provided by the US Census (2009-2013) and specifically the Primary Service Area of Saint Mary's Hospital.

Table 1. CHA Service Area Population Findings

Demographic Category	Indicator	Primary Service Area Total		Connecticut Total	
Total Population	Total Population	168,145	100%	3,583,561	100%
Age	Less than 18 Years Old	40,417	24%	802,718	22%
	Over 64 Years Old	22,263	13%	519,616	15%
Race and Ethnicity	White	96,590	57%	2,526,401	70%
	Black	21,484	13%	337,758	9%
	Hispanic	42,329	25%	496,393	14%
	Asian	3,124	2%	140,592	4%
	Other	4,618	3%	81,871	2%
Gender	Male	81,194	48%	1,745,194	49%
	Female	86,951	52%	1,838,367	51%

Source: US Census (2009-2013) and primary service area determined by Connecticut Hospital Association (2015)

Saint Mary's Facilities

Saint Mary's Hospital

Saint Mary's Hospital is a Catholic, not-for-profit, community teaching hospital that has been serving patients in Waterbury, Connecticut since 1909. The hospital offers a wide variety of medical services, educational classes, and patient resources in addition to a Level II Trauma Center, pediatric emergency room, award winning cardiac and stroke care and exceptional surgical services.

Naugatuck Valley Surgical Center

Naugatuck Valley Surgical Center (NVSC) is an outpatient department of Saint Mary's Hospital which offers state-of-the-art operating rooms and post-operative patient care areas for ambulatory surgery. The surgical center staff is experience in a wide variety of specialties including Gastroenterology, General Surgery, Gynecology, Ophthalmology, Oral/Dental Surgery, Orthopedics , Otorhinolaryngology (ENT), Pain Management, Plastic Surgery, Podiatry and Urology

The Harold Leever Regional Cancer Center and Saint Mary's Hospital Oncology Center

The Harold Leever Regional Cancer Center is a joint partnership of Saint Mary's Hospital and Waterbury Hospital offering the highest quality care for cancer patients. In the building sits Saint Mary's Hospital Oncology Center which provides the most up-to-date treatment and protocols for patients right here in our community, and is located right in Waterbury, just off I-84.

Saint Mary's Medical Imaging Center

From X-rays, MRI and CT scans to images taken at a nuclear level, Saint Mary's is dedicated to providing advanced radiology services. Saint Mary's Medical Imaging Center is fully digital, which offers many advantages, including improved image quality and enhanced speed.

Saint Mary's Hospital Urgent Care Centers (Cheshire, Naugatuck, Wolcott, Waterbury)

Saint Mary's has expanded its footprint to offer four urgent care locations that provide a greater access to care for patients in the service area. The urgent care centers offer a wide array of services including x-ray, laboratory services, EKGs, immunizations and vaccines, pediatric care, and work-related injuries.

Community Health Needs Assessment Process

Saint Mary's Hospital's 2016 CHNA is based on data and input from multiple sources. These include:

- **DataHaven Health and Wellbeing survey**: Saint Mary's participated in this data collection effort through the Greater Waterbury Health Improvement Partnership. The survey was conducted statewide, providing a valuable data set across multiple communities. A separate report was developed focusing on the Waterbury community.
- **GWHIP Steering Committee Strategic Review**: the founding partners of the Greater Waterbury Health Improvement Partnership met to review our collective experience and insights from 2013-2016. We discussed the performance of the various workgroups, initiatives implemented, and the expected impact. Based on this assessment several changes were recommended.
- **CDC Learning Cohort**: Waterbury was one of thirteen communities in the country selected to participate in this learning opportunity**.** The learning cohort offered access to best practices, insight into what's worked in other communities, and specific coaching
- **Trinity Health Community Health & Well Being**: As Saint Mary's prepared to become a member of Trinity Health, we were afforded the opportunity to have discussions with colleagues from Hartford as well as the system office in Lavonia, Michigan. These discussions, although preliminary in nature, have begun to shape our planning process. We expect that we will gain further benefit as we move ahead once fully integrated in to the Trinity Health regional health ministry.

Each of these inputs contributed a unique perspective to the overall plan.
Additional inputs and resources are listed below.

Community Primary Data Sets
Community Programming Surveys
The data was gathered from information residents who attended Saint Mary's Hospital's community outreach programs specifically with the Spirit of Women Network. This came in the form of post-event surveys and verbal conversations.

Community Leader Discussions/Executive Meeting
In addition to gathering quantitative data, Saint Mary's obtained input from important community stakeholders regarding the health needs of the community. Interviews and informal discussions with community leaders in the Greater Waterbury area were also used to expand the knowledge of the issues affecting the service area. Some if not most of the community leaders that were involved in discussions grew up in the area and represented broad interests in our community including: leaders of medically underserved and low-income populations, persons with expertise or special knowledge in public health, and persons who lead local health agencies. In addition, a comprehensive community executive meeting was held in June 2016 and informal discussions with key informants in regards to Saint Mary's service area were completed.

Community Health Needs Assessment Data Sets
The following data sets were used and analyzed in order to obtain secondary data for Saint Mary's 2016 CHNA.

The ALICE Study of Financial Hardship Report
In 2012, the United Way completed a report titled ALICE (Asset Limited, Income Constrained, and Employed) which represented the growing number of individuals and families who are working, but are unable to afford the basic necessities such as housing, food, child care, health care, and transportation.

State of Connecticut
The official website of the State of Connecticut (ct.gov). Several resources were used from the State of Connecticut's website primarily regarding education and public health datasets for the purposes of expanding the information in this CHNA.

US Center for Disease Control and Prevention
As the leader in the nation's public health concerns, the US Center for Disease Control and Prevention (CDC) provides insights and data on diseases, chronic to acute and curable to preventable.

County Health Rankings and Roadmaps (2016)
These are the data measures adopted by the Centers for Disease Control (CDC) as standard measures of community health by which to assess the nation's health and allows comparisons at national, state and local levels. They have been selected based on their relevance as indices of community health and their general availability for assessments at all levels. The information for this data can be found in Appendix 1 and is often referred to in this CHNA.

Healthy People 2020 (2014)
Healthy People 2020 was developed by the Office of Disease Prevention and Health Promotion to assist in creating societies of residents living long and healthy lives and specifically offers state-by-state data.

Saint Mary's Hospital Community Health Profile (2015)
The Saint Mary's Hospital Community Health Profile (2015) was provided by the Connecticut Hospital Association(CHA). Completed each year by CHA, the document provides data and support for Connecticut hospitals and their community partners particularly with the Community Health Needs Assessment. Within this community profile, data was used from CHA's ChimeData database, US Census, the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS), the Connecticut Department of Public Health, and several other sources.

The 2015 DataHaven Community Health and Wellbeing Survey
The public service organization, DataHaven, completed the DataHaven Community Health and Wellbeing Survey in 2015 as a grassroots and locally based effort to promote regional well-being and quality of life. Using telephone surveys, the company was able to receive data from nearly 17,000 residents of Connecticut of which 610 were surveyed from the City of Waterbury. The information from the survey was heavily used in this CHNA and provided necessary information for prioritization for Saint Mary's.

Research Limitations
It should be noted that the availability of secondary data may represent some research limitations.

Community Health Needs Assessment Findings

Saint Mary's utilized the "Invest in Your Community: 4 Considerations to Improve Health and Wellbeing for All" and the "County Health Rankings Model - Health Factors" as guide and framework for its work. The Centers for Disease Control and Prevention (CDC) created a detailed outline which has been used as the core of the Greater Waterbury Health Improvement Partnership it can be found on page 24 of this CHNA.

Using the CDC's graphic as a model, Saint Mary's focused on the four elements of good health:

- Socioeconomic Factors, which accounts for 40%
- Physical Environment, which accounts for 10%
- Health Behaviors, which account for 30%
- Clinical Care, which accounts for 20%

Socioeconomic Factors

Socioeconomic factors have the largest impact on one's health according the CDC model of community health and wellbeing accounting for 40% in the described model. Socioeconomic factors that affect good health include a combination of: education, employment, income, and community support. These factors are known as the "social determinants" of health.

Employment & Income

According to the 2012 ALICE (Asset Limited Income Constrained Employment) Report, the state of Connecticut had a poverty rate of 10% and a median household income of $67,276. These numbers compare well to the U.S. average poverty rate of 15%, and the median household income in U.S. of $51,371. When looking specifically at the city of Waterbury, one of Connecticut's largest cities the report showed that out of 40,992 households, 23% of the residents were living in poverty and an added 34% fell under the ALICE characterization totaling over 50% of households below the ALICE threshold. Additional information can be seen in Table 2. in regards to the ALICE Report.

Table 2. Key Facts and ALICE Statistics by Municipality, Connecticut, 2012

Municipality	Waterbury, New Haven County
Population	109,915
Households	40,992
Poverty %	23%
ALICE %	34%
Above ALICE Threshold %	43%
Gini Coefficient	0.45
Unemployment Rate	13%
Health Insurance Coverage %	86%
Housing Burden: Owner over 30%	42%
Housing Burden: Renter over 30%	60%

Source: United Way ALICE Report; American Community Survey

Saint Mary's primary and secondary service area as mentioned above encompasses 35 zip codes and 17 towns. On page 11, The ALICE and Poverty Rates by Towns can be seen in Table 3 and include information with the total households and the total % of ALICE and Poverty households pertaining to the specific town.

Table 3. ALICE and Poverty Rates by Town, 2012

Town	Total Households	% ALICE and Poverty
Beacon Falls	2,244	26%
Bethlehem	1,409	17%
Cheshire	9,641	15%
Middlebury	2,797	20%
Morris	967	27%
Naugatuck	12,588	40%
Oxford	4,420	13%
Plymouth	4,739	24%
Prospect	3,280	19%
Southbury	8,022	31%
Thomaston	3,192	27%
Waterbury	40,992	57%
Watertown	8,270	25%
Wolcott	5,947	23%
Woodbury	4,204	24%

Source: United Way ALICE Report, U.S. Department of Housing and Urban Development (HUD), U.S. Department of Agriculture (USDA), Bureau of Labor Statistics (BLS), Internal Revenue Service (IRS) and state Treasury, and ChildCare Aware, 2012; American Community Survey, 1 year estimate.
*Note: Plantsville, Connecticut (zip code: 06479) was not included in the service areas reported

Education

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. According to the U.S. Census Bureau, High school and higher education graduation rates are lower in Waterbury (79.6% and 16.0% respectively) than in Connecticut (86.3% and 29.3% respectively).

According to the County Health Rankings in Saint Mary's service area counties the percentage of students who graduate High School in four years from New Haven County is 81%, from Litchfield County is 89%, and Hartford County is 82%. As seen below in Table 4. in Saint Mary's Service area covered by the Connecticut Hospital Association, 20% of the residents have a Bachelor's Degree or higher, whereas 36% of the State of Connecticut hold such education.

Table 4. Socioeconomic Data by CHA Primary Service Area

Demographic Category	Indicator	Primary Service Area Total		Connecticut Total	
Socioeconomics	Below Poverty	29,226	18%	354,348	10%
	Bachelor's Degree or Higher	22,198	20%	886,514	36%

Source: US Census (2009-2013); primary service area determined by Connecticut Hospital Association (2015)

In recent reports from the 2013-2014 Connecticut Department of Education Chronic Absenteeism Report, Waterbury Public Schools are on the top of the list for chronic absenteeism in the district. Over 20% of students in the district fall into the category of chronically absent from school which is defined as any student with a calculated Average Daily Attendance (ADA) of less than or equal to 90%. This number was significantly higher when looking at chronic absenteeism in the Waterbury Public High School rates which were at 33.7% among the highest in the state of Connecticut.

Neighborhood and Community Safety

One of the most significant social determinants of health is the conditions in which residents have a sense of security and community within their geographic location. In order to better understand overall safety in the community in three different levels, data was taken from overall Connecticut respondents, Greater Waterbury and Waterbury. Within that data table below, one can see that overall the results for satisfaction with Greater Waterbury was 78% and in the city of Waterbury was 63%.

Table 5. Neighborhood Satisfaction

Are you satisfied with the city or area where you live?

	Connecticut	Greater Waterbury	Waterbury
Yes	82%	78%	63%
No	17%	22%	36%
Don't Know	1%	1%	1%
Refused	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

While the overall satisfaction in Greater Waterbury and Waterbury are less than the Connecticut average ranking quite high at 82%, the responses for the safety of residents in their neighborhood merits further examination which can be seen below at staggering rates below the Connecticut's average.

Table 6. Residents Safety

The job done by the police to keep residents safe…

	Connecticut	Greater Waterbury	Waterbury
Excellent	30%	30%	15%
Good	45%	41%	35%
Fair	15%	16%	28%
Poor	6%	9%	16%
Don't know enough about it in order to say	4%	3%	5%
Refused	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Table 7. Neighborhood Responses

The information below portrays the percentage of respondents that stated that they "strongly agreed" with the specific questions asked in the DataHaven Health and Wellbeing Survey.

Questions answered with "Strongly Agree"	Connecticut	Greater Waterbury	Waterbury
There are safe sidewalks and crosswalks on most of the streets in my neighborhood.	39%	32%	39%
I do not feel safe to go on walks in my neighborhood at night.	16%	18%	29%
People in my neighborhood can be trusted.	54%	55%	33%
Children and youth in my town generally have the positive role models they need around here.	38%	38%	17%

Source: DataHaven Health and Wellbeing Survey

Transportation

Comparable to state average, the Greater Waterbury service area residents have access to a car or have their own car as the primary means of transportation as seen in Table 8. Public transportation is available in this city of Waterbury and immediate suburban towns but only 8% of respondents in the DataHaven survey said to use it. With a 12% response, most residents in Waterbury would be more apt to get a ride from a friend or relative than to use public transportation as a primary means of transportation.

Table 8. Access to Car

Do you have access to a car when you need it? Would you say you have access…

	Connecticut	Greater Waterbury	Waterbury
Very often	85%	83%	74%
Fairly often	4%	5%	4%
Sometimes	5%	5%	8%
Almost never	1%	1%	3%
Never at all	5%	6%	11%
Don't Know	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Physical Environment

According to the CDC model, where you live is one of the greatest predictors of how healthy you will be and accounts for 10% in the "Invest in Your Community" Model. Living in a safe neighborhood that has adequate environmental factors can lead to higher rates in overall wellbeing.

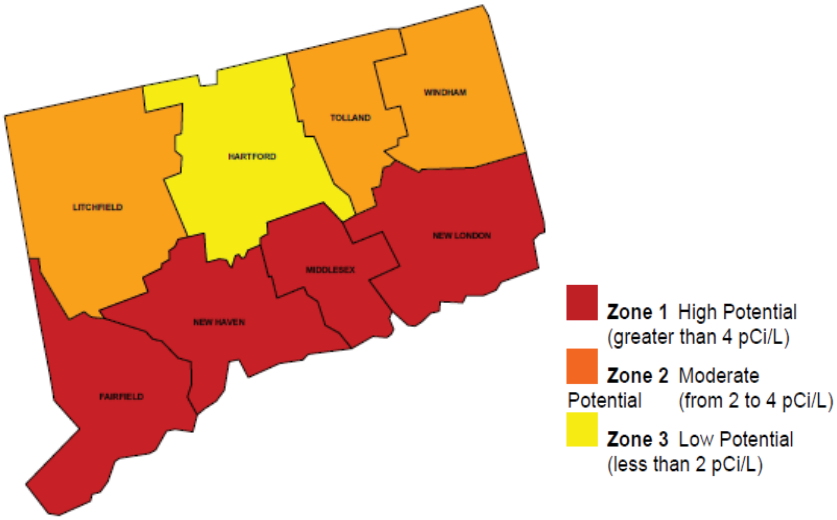
Air Quality

Air Quality Index AQI is a number used by government agencies to communicate to the public how polluted the air is currently or how polluted it is forecast to become. As the AQI increases, an increasingly large percentage of the population is likely to experience increasingly severe adverse health effects including asthma and cardiovascular disease. According to the U.S. Environmental Protection Agency in 2013 the Air Quality Index (AQI) was significantly worse in the city of Waterbury at 106 compared to the United States Index average of 75.

Radon Zones

According to the U.S. Environmental Protection Agency, New Haven County, which occupies Saint Mary's Hospital service area, falls within the EPA's Radon Zone 1 indicating a High Potential for radon exposure for that service area community. As stated by the World Health Organization, radon is the second most important cause of lung cancer in many countries and lung cancer risk rises 16% per 2.7 pCi/L increase in radon exposure.

Figure 2. Map of Radon Zones in Connecticut



Source: US EPA (2013); primary service area determined by Connecticut Hospital Association (2015)

Housing

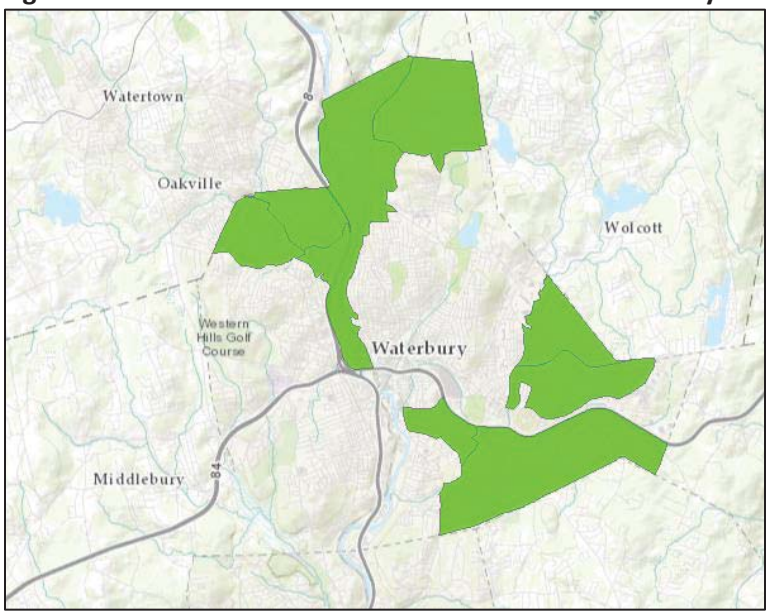
Housing insecurity is an issue that continues to impact Saint Mary's service area residents. Over a third of the population in Saint Mary's service area is housing cost burdened, with rates close to 35% in Waterbury (U.S. Census Bureau, 2010-2014). According to the US Census Bureau, housing cost burden is defined as more than 30% of income going towards housing expenses. A lack of affordable housing can contribute to many factors including homelessness and housing instability and insecurity.

Health Behaviors

The third factor to be discussed is health behaviors that account for 30% of the "Invest In Your Community" Model. This category includes topics such as diet, exercise, and substance use. These can also be defined as daily routines that residents in a community have that play a role in their overall health and wellbeing.

Diet and Exercise

Figure 3. USDA Food Atlas Food Desert Areas in Waterbury



Source: USDA Food Access Research Atlas; accessed 8/17/16

The USDA Food Access Research Atlas identifies low income and low access census tracts in order to greater understand the ability for members of the population to have access to a supermarket for nourishing and healthy food options. Places which have a great distance to a supermarket is known as a food desert. As seen in Figure 3 in green, Waterbury has several identified areas that are considered food deserts.

Table 9. Weekly Exercise

In an average week, how many days per week do you exercise?

	Connecticut	Greater Waterbury	Waterbury
None	17%	20%	26%
One	6%	5%	6%
Two	13%	10%	10%
Three	19%	20%	17%
Four	12%	10%	8%
Five	12%	12%	12%
Six	5%	4%	2%
Seven	16%	17%	17%
Don't Know	1%	1%	1%
Refused	1%	1%	1%

Source: DataHaven Health and Wellbeing Survey

Table 10. Body Mass Index
BMI (Based on Q24 Weight and Q25 Height DataHaven Survey)

	Connecticut	Greater Waterbury	Waterbury
Underweight	2%	2%	2%
Normal weight	37%	33%	27%
Overweight	36%	37%	37%
Obese	26%	28%	33%

Source: DataHaven Health and Wellbeing Survey

Alcohol and Substance Use

Substance use in the state of Connecticut and specifically in the city of Waterbury has been a large public health concern with the rising rates overdose cases. As one of the top five conditions for Saint Mary's Emergency Department non-admission rates, substance use and abuse remains a problem in particular with prescription and opioid based medications.

Tobacco Use

Tobacco use is a major concern in Waterbury especially with the number of residents who currently smoke on a daily basis. According to the DataHaven Health and WellBeing Survey 45.0% of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 40.0% across the state. In addition, more than half (55.0%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (37.0%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months by not smoking for 24 hours or more.

Table 11. Current Tobacco Use
(If smoked 100 cigarettes in entire life) Do you currently smoke cigarettes every day, some days or not at all?

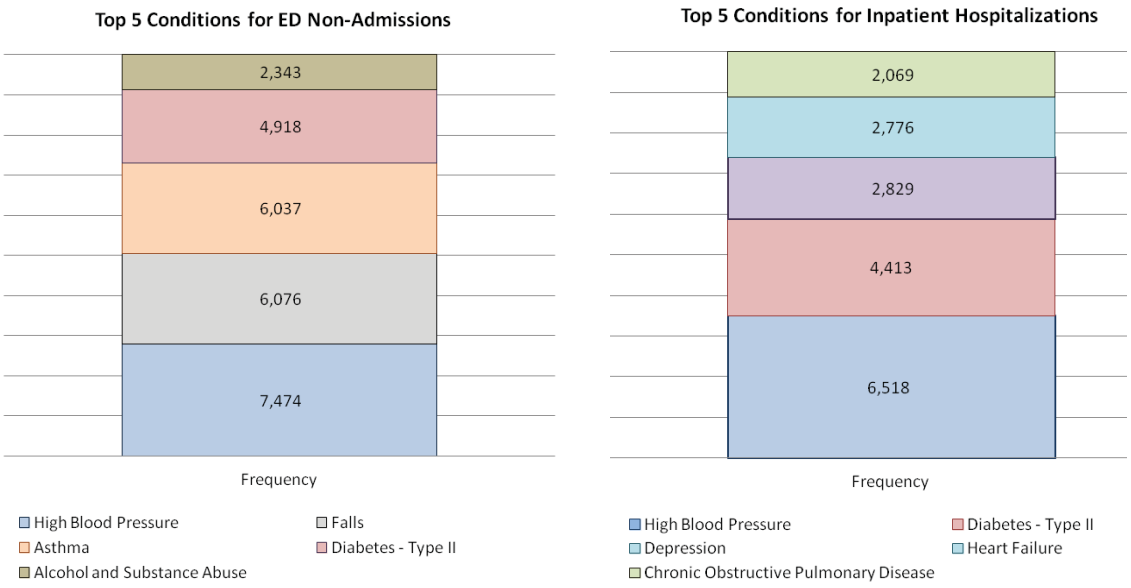
	Connecticut	Greater Waterbury	Waterbury
Every day	26%	29%	40%
Some days	11%	11%	15%
Not at all	63%	60%	45%
Don't know	0%	0%	0%
Refused	0%	0%	0%
Smoking Prevalence (based on several questions in DataHaven Survey)	15%	17%	25%

Source: DataHaven Health and Wellbeing Survey

Clinical Care

The last factor that is mentioned in the CDC model is clinical care, which accounts for 20% of good health. To better understand this for Saint Mary's primary service area several data sets have been used from the Connecticut Hospital Association in order to better understand the access to care as well as the quality of care given to patients.

Figure 4. Inpatient Hospitalizations and Conditions for ED Non-Admissions

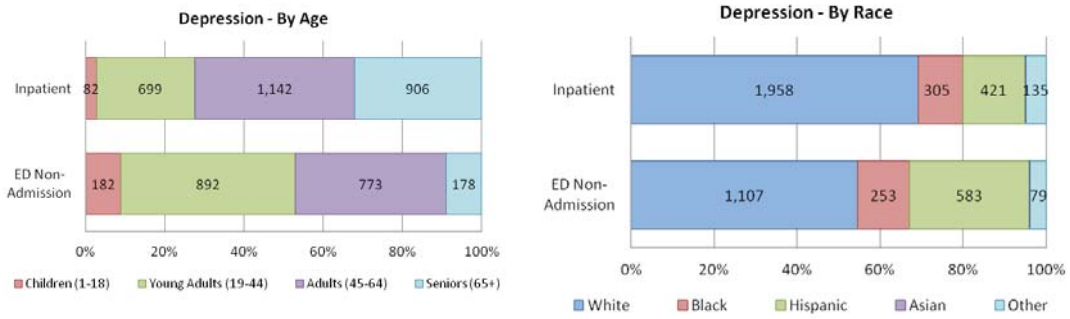


Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Mental Health

Mental and Behavioral Health continue to have a dramatic impact on the overall health of residents in the Saint Mary's service area. Feeling physically unwell can impact a person's emotional wellbeing and if not taken seriously can lead to depression and anxiety. As seen in the figures below, the largest group of patients at Saint Mary's were white adults age 45 to 64 according to the 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association.

Figure 5. Depression by Age and Race



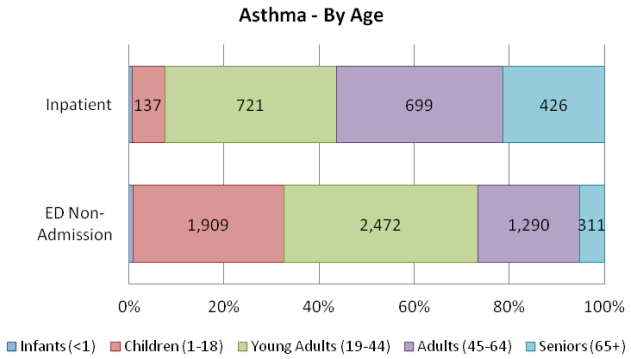
Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

In addition to depression, suicide and self-inflicted injuries were an increasing health concern for the hospital with 243 ED non-admission patients of which 142 were insured with Medicaid (Connecticut Hospital Association, 2015).

Asthma

In Greater Waterbury there are fare to many area children and adults that have poorly managed asthma which results in significant amounts of emergency department visits and potential inpatient admissions. Both pediatric and adult asthmatics have potential gaps in the education of management of asthma and its potential life threating symptoms. Despite being in line with the Connecticut average of respondents having Asthma in the Greater Waterbury Area and City of Waterbury, of the respondents that answered "yes" to having Asthma the rate was double the Connecticut average at (12% and 16% respectively) for having an Asthma attack at least once a day and using a prescription inhaler (DataHaven Health and Wellbeing Survey, 2015).

Figure 6. Asthma by Age



Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Oral Health

According to the American Dental Association, most dental Emergency Room visits can be reduced or eliminated by regular visits to a dentist. In the DataHaven Health and Wellbeing Survey, almost 1 in 3 residents of Waterbury reported not have been to a dentist for more than a year (2015). In addition, Emergency Department visits for dental conditions were proportionally overrepresented among blacks and Hispanics in Saint Mary's service area.

Cancer

Cancer affects Waterbury residents at an (age-adjusted) rate of 491.1 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 491.1 is similar to or lower than that of peer cities such as Hartford and New Haven which can be seen in Table 13.

Table 12. Cancer Incidence in Waterbury per 100,000 (2010)

Primary Cancer Site	Crude Rate	Age-Adjusted Rate
Breast (Female)	139.0	128.9
Colorectal*	60.0	57.6
Lung & Bronchus*	77.4	74.8
Prostate	115.4	120.8
All sites	506.3	491.1

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health
*Denotes that State-Town Comparison rates are higher than the state rate.

Table 13. Cancer Incidence by City per 100,000 (2010)

	Connecticut	Waterbury	Hartford	New Haven
All sites (Age-adjusted)	489.3	491.1	472.5	515.9

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health

The mortality rate per 100,000 for all cancer types is 146.7 in Connecticut which is surpassing the Healthy People 2020 target of 161.4 (2014).

Table 14. Overall Cancer Deaths by Total in Connecticut

	2010	2011	2012	2013	2014
Total*	163.4	158.4	151.9	148.4	146.7

Source: Healthy People 2020 (2014), State-Level Data: Connecticut
*Total (Age adjusted, per 100,000 population)

Diabetes

Not only in the Saint Mary's service area and the state of Connecticut has diabetes been a major health concern but across the United States. According to the Center for Disease Control, 29 million Americans have diabetes and 86 million American adults aged 20 years and older have prediabetes. As seen below, residents in Waterbury have been told by a doctor more frequently that they have diabetes than in the Greater Waterbury area and in Connecticut. The unease with this number is that residents that have diabetes are at higher risk for serious health complications including: blindness, kidney failure, heart disease, stroke, and potential loss of extremities.

Table 15. Have you ever been told by a doctor or health professional that you have diabetes?

Connecticut	Greater Waterbury	Waterbury
9%*	11%*	13%*

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

Cardiovascular Disease

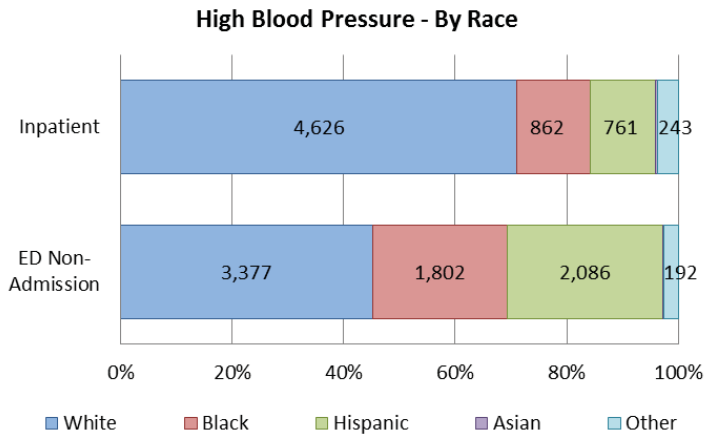
According to the Connecticut Hospital Association, high blood pressure was the most prevalent condition among inpatient and Emergency Department Non-Admission settings. A total of 35% of residents in Waterbury responded "yes" to having been told by their doctor or health professional that they had high blood pressure or hypertension which are contributing factors to (other than obesity and lack of physical exercise) to more serious cardiovascular disease.

Table 16. Have you ever been told by a doctor or health professional you have high blood pressure or hypertension?

Connecticut	Greater Waterbury	Waterbury
28%*	32%*	35%*

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

Figure 7. High Blood Pressure by Race



Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Barriers to Care

Access to care remains one of the top concerns for Saint Mary's and its patients in the community. The tables below report access to services, insurance and prescription medications from the DataHaven Health and Wellbeing Survey.

Table 17. During the past 12 months, was there any time when you didn't get the medical care you needed?

	Connecticut	Greater Waterbury	Waterbury
Yes	7%	9%	10%
No	92%	91%	89%
Don't know	0%	0%	0%
Refused	0%	0%	1%

Source: DataHaven Health and Wellbeing Survey

Table 18. And was there any time during the past 12 months when you put off or postponed getting medical care you thought you needed?

	Connecticut	Greater Waterbury	Waterbury
Yes	21%	20%	22%
No	79%	80%	77%
Don't know	0%	0%	0%
Refused	1%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Table 19. If postponed or medical care not given, what was the reasoning?

	Connecticut	Greater Waterbury	Waterbury
Cost	49%	45%	45%
Health insurance was not accepted (Doctor's office or Hospital)	16%	12%	14%
Health insurance did not cover treatment	28%	33%	35%
Appointment was not in a reasonable amount of time	25%	27%	30%
The medical problem did not seem serious enough	46%	43%	39%

Source: DataHaven Health and Wellbeing Survey

Strategies to Address Community Health Needs

Selection of the Community Health Priorities and Future Planning

In May 2016, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the GWHIP data and planning for the future. The meeting was initiated by partners of the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss the commitment to the Greater Waterbury area and discuss future prioritizations of the organization and its members.

The objectives of the session were:

- To review recently compiled DataHaven Community Health and Wellbeing data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

Prioritization Process

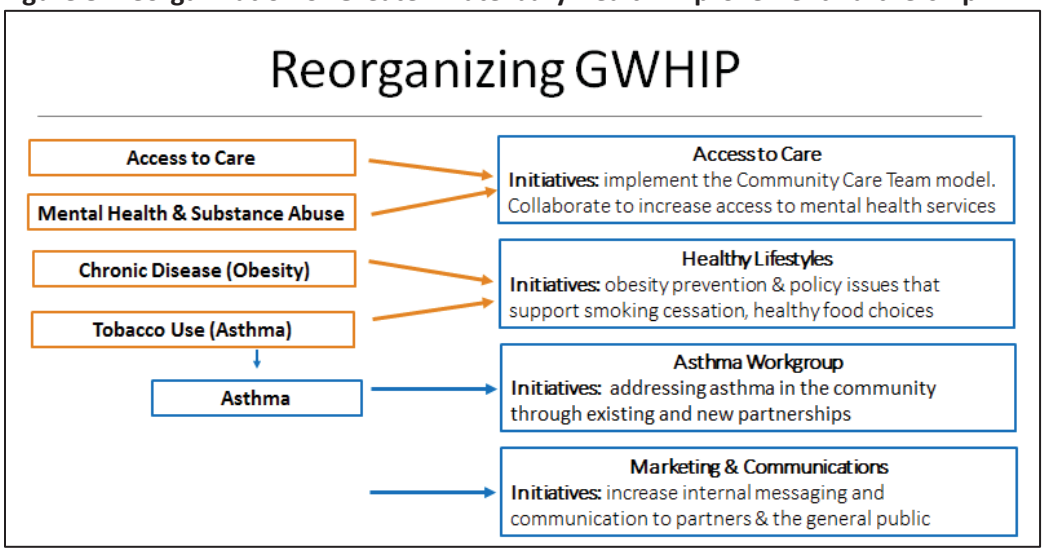
Executive leaders of the Connecticut Community Foundation, City of Waterbury Health Department, and Greater Waterbury Health Improvement Partnership facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview of the DataHaven Health and Wellbeing Data, meeting participants were provided with information regarding the prioritization process, criteria to consider moving forward with key areas of focus, and other aspects of health improvement planning. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community and how they would fit into the prioritization areas.

Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted in order to touch on several health initiatives:

Figure 8. Reorganization of Greater Waterbury Health Improvement Partnership



Strategies to Address Community Health Needs

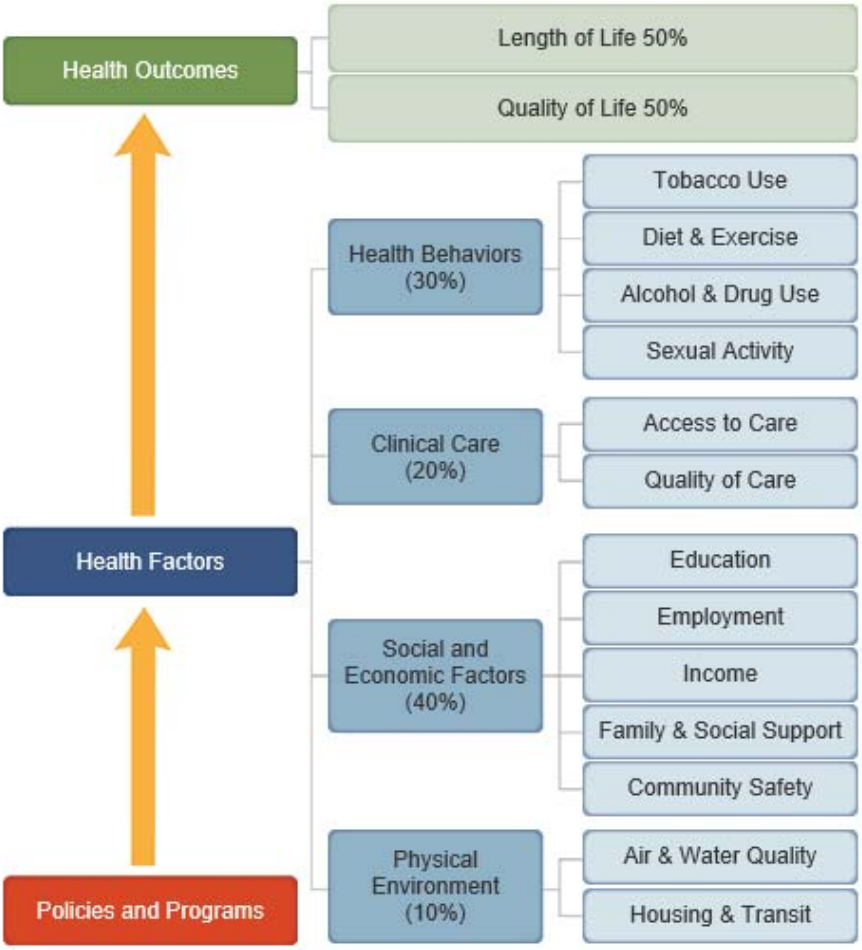
Saint Mary's Hospital will develop an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work will be completed by February 15, 2017 is supported by community-wide efforts and leadership from the executive team and board of directors.

Rationale for Community Health Needs Not Addressed

Saint Mary's Hospital plans to address all of the prioritized community health needs identified through the 2016 Community Health Needs Assessment and prioritized by community representatives.

Invest in Your Community Template

County Health Rankings Model - Health Factors



Appendices

Appendix 1. Community Health Rankings

Saint Mary's Hospital County Health Rankings

Health Outcomes Rank of 6 (out of 8 counties)

Health Factors Rank of 7 (out of 8 counties)

Measures	New Haven County	Litchfield County	Hartford County	State
Health Outcomes				
Length of Life				
Premature death /100,000	5800	5500	5700	5300
Quality of Life				
% Adults reporting fair or poor health	13%	9%	13%	14%
Avg. physically unhealthy days/month	2.9	2.5	3.1	3.2
Avg. mentally unhealthy days/month	3.5	3.2	3.4	3.7
% Live births with low birth weight <2500g	8%	7%	9%	8%
Health Factors				
Health Behaviors				
% Adults report currently smoking cigarettes	14%	13%	13%	15%
% Adults reporting BMI >= 30	26%	23%	27%	25%
Food environment index	7.6	8.5	7.7	7.9
% Adults 20+ reporting no leisure-time physical activity	23%	21%	23%	22%
% Pop. with adequate access to locations for physical activity	96%	90%	96%	94%
% Adults reporting binge drinking	16%	19%	17%	18%
% Alcohol-impaired driving deaths	28%	28%	37%	33%
Chlamydia rate /100,000	440.3	174.4	418.9	355.8
Teen birth rate /1,000 female pop., ages 15-19	22	11	24	19
Clinical Care				
% Pop. under age 65 without health	11%	10%	10%	11%
Ratio of pop. to primary care physicians	1060: 1	1570: 1	1070: 1	1170: 1
Ratio of pop. to dentists	1360: 1	1650: 1	1000: 1	1230: 1
Ratio of pop. to mental health providers	270: 1	490: 1	230: 1	300: 1
Preventable hospital stays /1,000 Medicare	53	49	51	50
% Diabetic Medicare enrollees receiving	85%	88%	87%	86%
% Female Medicare enrollees receiving mammography	65%	65%	68%	67%
Social & Economic Factors				
% Students who graduate HS in 4 years	81%	89%	82%	86%
% Adults, age 25-44 with some college	65%	66%	68%	68%
% Pop. age 16+ unemployed but seeking work	7.2%	5.9%	6.9%	6.6%
% Under age 18 in poverty	18%	9%	18%	15%
% Adults without social/emotional support	N/A	N/A	N/A	N/A
% Children in single parent households	36%	21%	37%	31%
Violent crime /100,000	406	111	323	279
Injury mortality /100,000	57	57	56	53
Physical Environment				
Avg. daily fine particulate matter in micrograms/cubic meter (PM2.5)	10.5	10.7	10.5	10.5
% Pop. potentially exposed to water exceeding a violation limit /yr	N/A	N/A	N/A	N/A
% Households with severe housing problems	22%	16%	18%	19%
% Workforce driving alone to work	79%	83%	81%	79%
% Commuting 30+ mins to work, driving alone	32%	38%	27%	32%

Trinity Health
New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

November 30, 2016

RE: Docket Number: Trinity Health – New England Transfer of Ownership CON Conditions for:

- Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-31979-CON Transfer of Ownership of Saint Francis *Care*, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care*, Inc.

Dear Mrs. Roberts,

In accordance with Trinity Health – New England's approved CONs for the transfers of ownership of Saint Francis *Care,* Inc*,.* and Saint Mary's Health Systems, Inc. to Trinity Health Corporation and Trinity Health - New England and for the transfer of ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc*. (NKA Trinity Health – New England),* attached are the responses to the conditions set forth in each of the CON decisions.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

Docket Number: 15-32045-CON
Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

November 30, 2016

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Roberts:

In accordance with Items 6, 7, 8, 9 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

6. ***Until such time as the Services Plan is submitted, TH-NE shall provide OCHA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OCHA is imposing this Condition to ensure continued access to health care services for patient population.***

   In accordance with Condition 6 of the Order, Trinity Health – New England, Inc. ("TH-NE") is notifying OCHA that there are no plans to reallocate inpatient beds or relocate any outpatient services for Saint Mary's Hospital at this time.

7. ***Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:***
   - ***A. A list of the of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and***
   - ***B. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and***
   - ***C. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.***

   The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer.

   See Attachment 1.

8. ***For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:***

   a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The

categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category for the semi-annual period; and

Since August 1, 2016, the leaders within the functional areas at Saint Mary's Hospital have been working closely with Trinity Health and Trinity Health New England to identify and implement changes to realize cost savings opportunities. This process takes time to implement and we have not implemented any significant costs savings in the two month period ending September 30, 2016.

2. the effect of these cost savings on the clinical quality of care.

There has been no impact to clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/300 (statement of operations), or successor reports.

See Attachment 2.

9. ***For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016.***

   See Attachment 3 for financial indicators.

10. ***TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.***

In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 2

DESCRIPTION	CLASS	TYPE	ACQ DATE	AMT	Explanation	To be paid from
FABIUSTIRO ANESTHESIA MACHINES	MOVEABLE	MEDICAL	8/31/2016	59,992.08	2 new Anesthesia Fabious Tiro machines	Operating cash
INTELLIVUE MONITORS & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	50,254.20	2 new patient monitors with easy care cuffs	Operating cash
STERILIZATION CONTAINER	MOVEABLE	MEDICAL	8/31/2016	13,894.57	new sterilization container w/accessories	Operating cash
ISTAT 1 WIRELESS ANALYZER	MOVEABLE	MEDICAL	8/31/2016	28,060.47	new ISTAT 1 WIRELESS ANALYZER	Operating cash
SCOPES 0 DEG & 30 DEG CURETTATE	MOVEABLE	MEDICAL	8/31/2016	9,618.00	new scopes and tray sterilization sterrads	Operating cash
VC- 10 VACUUM	MOVEABLE	MEDICAL	8/31/2016	5,205.50	VC- 10 VACUUM curettate system	Operating cash
BLADDER SCAN BVI 9400	MOVEABLE	MEDICAL	8/31/2016	18,316.00	new Bladder scan w/rolling cart	Operating cash
LIPOSCULTPTOR & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	19,376.45	new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
SUTURE RETRIEVER ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	38,916.00	SUTURE RETRIEVER ACCESSORIES	Operating cash
SCOPE HOPKINS 11 30 DEG	MOVEABLE	MEDICAL	8/31/2016	9,300.40	Sheath High flow arthroscopy & Hopkins scope	Operating cash
B3000 BLACK BADGE & BATTERIES	MOVEABLE	MEDICAL	8/31/2016	20,552.00	B3000 BLACK BADGE & BATTERIES	Operating cash
CO2 MONITOR & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	5,453.04	CO2 MONITOR & ACCESSORIES	Operating cash
ARTIC SUN 5000E TEMP	MOVEABLE	NONMEDICAL	8/31/2016	50,494.00	Artic Sun 5000E Temp manage system & calibration test unit	Operating cash
OPTIPLEX 7040 PC & MONITORS	MOVEABLE	NONMEDICAL	8/31/2016	27,050.40	20 monitors & 10 Optiplex 7040 SFF w/dual monitor stands	Operating cash
BUILDING SIGN	MOVEABLE	NONMEDICAL	8/31/2016	2,200.00	new bldg signage	Operating cash
CONDENSING UNIT	MOVEABLE	NONMEDICAL	8/31/2016	23,316.00	replace condensing unit	Operating cash
HVAC CLEANING & SANTIZING	MOVEABLE	NONMEDICAL	8/31/2016	23,203.50	HVAC duct CLEANING & SANTIZING	Operating cash
FIRE & SMOKE DAMPER	MOVEABLE	NONMEDICAL	8/31/2016	3,650.00	FIRE & SMOKE DAMPER	Operating cash
FLOOR SCRUBBERS SINGLE & DUAL	MOVEABLE	NONMEDICAL	8/31/2016	14,248.40	New Floor scrubbers (single & dual) and burnisher	Operating cash
DEHUMIDIFIER TRAGER BASEMENT	MOVEABLE	NONMEDICAL	8/31/2016	2,647.50	deposit for DEHUMIDIFIER in TRAGER BASEMENT	Operating cash
EXPANSION VALVE TRAGER	MOVEABLE	NONMEDICAL	8/31/2016	2,618.00	depoisit for EXPANSION VALVE in TRAGER office	Operating cash
WALL COVERING - AUDITORIUM	MOVEABLE	NONMEDICAL	8/31/2016	10,530.30	deposit for WALL COVERING in AUDITORIUM	Operating cash
COOLONG COL REPLACEMENT	MOVEABLE	NONMEDICAL	8/31/2016	45,350.00	AHU-1 Cooling coil replacement	Operating cash
CATH LAB # 2 RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	70,203.36	CATH LAB # 2 RENOVATION	Operating cash
SLEEP LAB RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	24,400.75	SLEEP LAB RENOVATION	Operating cash
BOARDROOM RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	18,518.50	Boardroom Project is now complete	Operating cash
10 FT HOSES	MOVEABLE	NONMEDICAL	8/31/2016	647.44	4 each of 02 CS hoses & Air CS hoses 10FT Diss Hand	Operating cash
REVERSE OSMOSIS SYSTEM	MOVEABLE	NONMEDICAL	8/31/2016	16,500.00	REVERSE OSMOSIS SYSTEM	Operating cash
HARMONYAIR LIGHT SYSTEM	FIXED	NONMEDICAL	8/31/2016	49,805.83	2 Harmonyair G5 Dual Pkg Light systems	Operating cash
RECUMBENT CROSS TRAINER	MOVEABLE	MEDICAL	9/30/2016	4,189.00	RECUMBENT CROSS TRAINER-the Foundation reimbursed us for this purchase	Foundation Funds
CONTAINERS FOR STERILIZATION	MOVEABLE	MEDICAL	9/30/2016	5,130.40	75 sterilization containers	Operating cash
TITANIUM GE MRI TOOL KIT	MOVEABLE	MEDICAL	9/30/2016	3,775.95	TITANIUM GE MRI TOOL KIT	Operating cash
LIPOTOWER ASPIRATOR / INFIL	MOVEABLE	MEDICAL	9/30/2016	6,922.35	new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
LIGHT HANDLE CAMERA COVER	MOVEABLE	MEDICAL	9/30/2016	295.92	LIGHT HANDLE CAMERA COVER	Operating cash
CART, SINGLE TIER CORNER	MOVEABLE	MEDICAL	9/30/2016	10,865.17	CART, SINGLE TIER CORNER	Operating cash
CAMERA, CODER & STORAGE	MOVEABLE	MEDICAL	9/30/2016	5,500.00	CAMERA, CODER & STORAGE	Operating cash
VOLUSON P8	MOVEABLE	MEDICAL	9/30/2016	8,480.00	VOLUSON P8	Operating cash
CARBON FIBER BOARD	MOVEABLE	NONMEDICAL	9/30/2016	2,250.00	Board, Carbon fiber TTL ACS Radial	Operating cash

CHESHIRE UC INSTALL	FIXED	NONMEDICAL	9/30/2016	8,485.00	Security Alarm install	Operating cash
DELL OPTOPLEX 7040	MOVEABLE	NONMEDICAL	9/30/2016	14,596.44	24 monitors & 12 Optiplex 7040 SFF w/dual monitor stands, plus software	Operating cash
MARKETING FURNITURE	MOVEABLE	NONMEDICAL	9/30/2016	7,144.73	MARKETING FURNITURE-chairs, credenza, tabletop, etc	Operating cash
NVSC PAINTING (WATER DAMAGE)	BLDG IMPR	NONMEDICAL	9/30/2016	5,020.00	interior painting from water damage	Operating cash
NVSC PAINTING (WATER DAMAGE)	BLDG IMPR	NONMEDICAL	9/30/2016	28,024.00	interior painting from water damage	Operating cash
COUNTER FOR PSYCHIATRIC WARD	FIXED	NONMEDICAL	9/30/2016	2,527.20	Counter Fabrication	Operating cash
FEASABILITY STUDY OPEN OFFICE	BLDG IMPR	NONMEDICAL	9/30/2016	2,545.00	Prof srvs for FEASABILITY STUDY OPEN OFFICE	Operating cash
COUNTER TOPS THROUGHOUT HOSPITAL	FIXED	NONMEDICAL	9/30/2016	15,880.90	Labor & Materials for COUNTER TOPS THROUGHOUT HOSPITAL	Operating cash
AUDITORIUM RENOVATION	BLDG IMPR	NONMEDICAL	9/30/2016	18,662.55	Prof Srvs for AUDITORIUM RENOVATION	Operating cash
FIRE STOP	BLDG IMPR	NONMEDICAL	9/30/2016	9,818.00	FIRE STOP Labor & Materials	Operating cash
MAIN MEGAWATT METER REPLACEMENT	FIXED	NONMEDICAL	9/30/2016	2,750.00	MAIN MEGAWATT METER REPLACEMENT	Operating cash
EPOXY COATED SHOWER BASE	MOVEABLE	NONMEDICAL	9/30/2016	10,455.00	EPOXY COATED SHOWER BASE	Operating cash
BLASIUS 2014 CHEVROLET CRUZE	AUTO	NONMEDICAL	9/30/2016	12,805.60	BLASIUS 2014 CHEVROLET CRUZE	Operating cash
SLEEP LAB BUDGETED CONTRACT	BLDG IMPR	NONMEDICAL	9/30/2016	49,863.27	SLEEP LAB RENOVATION	Operating cash
MEP	BLDG IMPR	NONMEDICAL	9/30/2016	1,400.00	MEP-SLEEP LAB RENOVATION	Operating cash
RODI PIPING & INSTALL	FIXED	NONMEDICAL	9/30/2016	13,500.00	RODI PIPING & INSTALL	Operating cash

Regular additions	915,209.17
CIP project addtions	2,156,778.13
Total additions	3,071,987.30

Project Name	Project Description	Balance as of 7/31/16	Aug-Sep Additions	Balance as of 9/30/16	Project Start Date	Project expected end date	Project Budget	To be paid from
Oncology Center Project	Renovations to Dr Bowen's office located in the HLRCC	495,723.17	145,129.30	640,852.47	Apr-16	FY 2017	940,000	Operating cash
MRI Project	Renovations to new MRI area and Behavoiral Health in Emer Rm - 4 Phases to project	3,387,211.50	591,856.05	3,979,067.55	Sep-15	FY 2017	5,800,000	Operating cash, plus a 767,013 from a State grant
Atrion Project	Phase I of new phone system project	529,483.69	38,021.76	567,505.45	Jan-16	Nov-16	652,550	Operating cash
Cheshire Project	New construction for a Cheshire Urgent Care Ctr and a Primary Care/Specialty Practice	411,202.86	1,173,005.58	1,584,208.44	Mar-16	FY 2017	2,320,388	Operating cash
Northwest 911 Project	Renovations to 2nd floor of Lawlor Bldg for 911 Call Center	342,014.94	6,475.00	348,489.94	Feb-16	Nov-16	250,000	Operating cash
Cardiac Cath Lab Project	Renovations for a new Cardiac Cath Lab	450,631.00	198,601.69	649,232.69	May-16	FY 2017	815,823	Operating cash
Naugatuck Urgent Care	Construction for a new Urgent Care Ctr in Naugatuck - Project was put off until after FY2017, expenses were for Architect designs	7,377.50	3,688.75	11,066.25	FY 2018	FY 2019	2,100,000	Operating cash
		Total	2,156,778.13					

ATTACHMENT 2

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$13,310,000	$20,572,000	$7,262,000	55%
2	Short Term Investments	$17,000	$23,000	$6,000	35%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$28,548,000	$24,965,000	($3,583,000)	-13%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,701,000	$3,889,000	$188,000	5%
8	Prepaid Expenses	$3,301,000	$2,930,000	($371,000)	-11%
9	Other Current Assets	$3,792,000	$3,114,000	($678,000)	-18%
	Total Current Assets	**$52,669,000**	**$55,493,000**	**$2,824,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$14,764,000	$15,480,000	$716,000	5%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$20,166,000	$6,000	($20,160,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$34,930,000**	**$15,486,000**	**($19,444,000)**	**-56%**
5	Interest in Net Assets of Foundation	$4,908,000	$5,549,000	$641,000	13%
6	Long Term Investments	$124,000	$10,973,000	$10,849,000	8749%
7	Other Noncurrent Assets	$25,663,000	$25,740,000	$77,000	0%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$205,415,000	$91,358,000	($114,057,000)	-56%
2	Less: Accumulated Depreciation	$139,994,000	$2,656,000	($137,338,000)	-98%
	Property, Plant and Equipment, Net	**$65,421,000**	**$88,702,000**	**$23,281,000**	**36%**
3	Construction in Progress	$0	$7,780,000	$7,780,000	0%
	Total Net Fixed Assets	**$65,421,000**	**$96,482,000**	**$31,061,000**	**47%**
	Total Assets	**$183,715,000**	**$209,723,000**	**$26,008,000**	**14%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$21,871,000	$15,420,000	($6,451,000)	-29%
2	Salaries, Wages and Payroll Taxes	$3,962,000	$5,045,000	$1,083,000	27%
3	Due To Third Party Payers	$727,000	$1,262,000	$535,000	74%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$3,180,000	$89,000	($3,091,000)	-97%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$13,976,000	$15,912,000	$1,936,000	14%
	Total Current Liabilities	**$43,716,000**	**$37,728,000**	**($5,988,000)**	**-14%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$10,589,000	$0	($10,589,000)	-100%
	Total Long Term Debt	**$10,589,000**	**$0**	**($10,589,000)**	**-100%**
3	Accrued Pension Liability	$74,894,000	$83,306,000	$8,412,000	11%
4	Other Long Term Liabilities	$9,352,000	$10,485,000	$1,133,000	12%
	Total Long Term Liabilities	**$94,835,000**	**$93,791,000**	**($1,044,000)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$27,411,000	$59,686,000	$32,275,000	118%
2	Temporarily Restricted Net Assets	$1,922,000	$1,970,000	$48,000	2%
3	Permanently Restricted Net Assets	$15,831,000	$16,548,000	$717,000	5%
	Total Net Assets	**$45,164,000**	**$78,204,000**	**$33,040,000**	**73%**
	Total Liabilities and Net Assets	**$183,715,000**	**$209,723,000**	**$26,008,000**	**14%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$746,752,000	$136,060,000	($610,692,000)	-82%
2	Less: Allowances	$483,477,000	$90,093,000	($393,384,000)	-81%
3	Less: Charity Care	$3,174,000	$1,021,000	($2,153,000)	-68%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$260,101,000**	**$44,946,000**	**($215,155,000)**	**-83%**
5	Provision for Bad Debts	$8,180,000	$935,000	($7,245,000)	-89%
	Net Patient Service Revenue less provision for bad debts	**$251,921,000**	**$44,011,000**	**($207,910,000)**	**-83%**
6	Other Operating Revenue	$8,206,000	$1,078,000	($7,128,000)	-87%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$260,127,000**	**$45,089,000**	**($215,038,000)**	**-83%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$88,793,000	$15,392,000	($73,401,000)	-83%
2	Fringe Benefits	$27,562,000	$4,065,000	($23,497,000)	-85%
3	Physicians Fees	$6,099,000	$1,655,000	($4,444,000)	-73%
4	Supplies and Drugs	$41,890,000	$7,502,000	($34,388,000)	-82%
5	Depreciation and Amortization	$11,023,000	$2,659,000	($8,364,000)	-76%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$963,000	$5,000	($958,000)	-99%
8	Malpractice Insurance Cost	$3,338,000	$798,000	($2,540,000)	-76%
9	Other Operating Expenses	$61,720,000	$9,341,000	($52,379,000)	-85%
	Total Operating Expenses	**$241,388,000**	**$41,417,000**	**($199,971,000)**	**-83%**
	Income/(Loss) From Operations	**$18,739,000**	**$3,672,000**	**($15,067,000)**	**-80%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,315,000	$56,000	($1,259,000)	-96%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$1,207,000	($11,000)	($1,218,000)	-101%
	Total Non-Operating Revenue	**$2,522,000**	**$45,000**	**($2,477,000)**	**-98%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$21,261,000**	**$3,717,000**	**($17,544,000)**	**-83%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$21,261,000**	**$3,717,000**	**($17,544,000)**	**-83%**
	*** FY16 represents the period 8/1/16 - 9/30/16**				

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$15,091,000	$22,818,000	$7,727,000	51%
2	Short Term Investments	$17,000	$23,000	$6,000	35%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$32,905,000	$29,301,000	($3,604,000)	-11%
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$3,418,000	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,701,000	$3,889,000	$188,000	5%
8	Prepaid Expenses	$3,300,000	$3,515,000	$215,000	7%
9	Other Current Assets	$4,618,000	$3,192,000	($1,426,000)	-31%
	Total Current Assets	**$63,050,000**	**$66,156,000**	**$3,106,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$14,764,000	$15,480,000	$716,000	5%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$43,057,000	$19,537,000	($23,520,000)	-55%
	Total Noncurrent Assets Whose Use is Limited:	**$57,821,000**	**$35,017,000**	**($22,804,000)**	**-39%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$4,244,000	$15,428,000	$11,184,000	264%
7	Other Noncurrent Assets	$11,454,000	$6,263,000	($5,191,000)	-45%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$219,963,000	$95,973,000	($123,990,000)	-56%
2	Less: Accumulated Depreciation	$149,672,000	$2,835,000	($146,837,000)	-98%
	Property, Plant and Equipment, Net	**$70,291,000**	**$93,138,000**	**$22,847,000**	**33%**
3	Construction in Progress	$0	$7,873,000	$7,873,000	0%
	Total Net Fixed Assets	**$70,291,000**	**$101,011,000**	**$30,720,000**	**44%**
	Total Assets	**$206,860,000**	**$223,875,000**	**$17,015,000**	**8%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$22,665,000	$16,465,000	($6,200,000)	-27%
2	Salaries, Wages and Payroll Taxes	$6,002,000	$8,160,000	$2,158,000	36%
3	Due To Third Party Payers	$727,000	$1,262,000	$535,000	74%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$3,409,000	$337,000	($3,072,000)	-90%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$12,980,000	$13,842,000	$862,000	7%
	Total Current Liabilities	**$45,783,000**	**$40,066,000**	**($5,717,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$11,018,000	$586,000	($10,432,000)	-95%
	Total Long Term Debt	**$11,018,000**	**$586,000**	**($10,432,000)**	**-95%**
3	Accrued Pension Liability	$74,894,000	$83,306,000	$8,412,000	11%
4	Other Long Term Liabilities	$24,062,000	$22,539,000	($1,523,000)	-6%
	Total Long Term Liabilities	**$109,974,000**	**$106,431,000**	**($3,543,000)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$955,000	$2,588,000	$1,633,000	171%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$32,395,000	$56,272,000	$23,877,000	74%
2	Temporarily Restricted Net Assets	$1,922,000	$1,970,000	$48,000	2%
3	Permanently Restricted Net Assets	$15,831,000	$16,548,000	$717,000	5%
	Total Net Assets	**$50,148,000**	**$74,790,000**	**$24,642,000**	**49%**
	Total Liabilities and Net Assets	**$206,860,000**	**$223,875,000**	**$17,015,000**	**8%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$832,217,000	$152,831,000	($679,386,000)	-82%
2	Less: Allowances	$536,081,000	$100,069,000	($436,012,000)	-81%
3	Less: Charity Care	$1,072,000	$1,021,000	($51,000)	-5%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$295,064,000**	**$51,741,000**	**($243,323,000)**	**-82%**
5	Provision for Bad Debts	$9,675,000	$1,442,000	($8,233,000)	-85%
	Net Patient Service Revenue less provision for bad debts	**$285,389,000**	**$50,299,000**	**($235,090,000)**	**-82%**
6	Other Operating Revenue	$10,072,000	$1,365,000	($8,707,000)	-86%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$295,461,000**	**$51,664,000**	**($243,797,000)**	**-83%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$123,197,000	$22,400,000	($100,797,000)	-82%
2	Fringe Benefits	$32,298,000	$4,765,000	($27,533,000)	-85%
3	Physicians Fees	$9,916,000	$1,659,000	($8,257,000)	-83%
4	Supplies and Drugs	$43,411,000	$7,978,000	($35,433,000)	-82%
5	Depreciation and Amortization	$11,636,000	$2,834,000	($8,802,000)	-76%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$980,000	$8,000	($972,000)	-99%
8	Malpractice Insurance Cost	$4,154,000	$1,088,000	($3,066,000)	-74%
9	Other Operating Expenses	$67,708,000	$11,150,000	($56,558,000)	-84%
	Total Operating Expenses	**$293,300,000**	**$51,882,000**	**($241,418,000)**	**-82%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Income/(Loss) From Operations	**$2,161,000**	**($218,000)**	**($2,379,000)**	**-110%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,565,000	$53,000	($1,512,000)	-97%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$963,000	($11,000)	($974,000)	-101%
	Total Non-Operating Revenue	**$2,528,000**	**$42,000**	**($2,486,000)**	**-98%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$4,689,000**	**($176,000)**	**($4,865,000)**	**-104%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$4,689,000**	**($176,000)**	**($4,865,000)**	**-104%**
	*** FY16 represents the period 8/1/16 - 9/30/16**				

ATTACHMENT 3

	Saint Mary's Hospital (Hospital Only)	Month		Year to Date	
		Sept 2016	Prior Year	Sept 2016*	Prior Year
A.	**Operating Performance**				
	Operating Margin	10.9%	9.0%	8.1%	7.2%
	Non-Operating Margin	0.1%	-6.0%	0.1%	1.0%
	Total Margin	11.0%	3.0%	8.2%	8.2%
	Bad Debt as % of Gross Revenue	0.1%	0.4%	0.7%	1.2%
B.	**Liquidity**				
	Current Ratio	1.76	1.62	1.79	1.62
	Days Cash on Hand	31	23	31	23
	Days in Net Accounts Receivable	37	41	37	41
	Average Payment Period	52	61	52	61
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	-	0.32	-	0.32
	Long-term Debt to Capitalization	-	0.24	-	0.24
	Unrestricted Cash to Debt	231.15	0.97	231.15	0.97
	Times Interest Earned Ratio	1170.1	30.5	735.40	22.65
	Debt Service Coverage Ratio	214.8	11.3	71.20	9.82
	Equity Financing Ratio	2.70	4.23	2.70	4.23
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 2,523	$ 1,821	$ 3,672	$ 18,739
	Revenue Over/(Under) Expense	$ 2,537	$ 601	$ 3,717	$ 21,261
	EBITDA	$ 3,866	$ 2,835	$ 6,335	$ 30,507
	Patient Cash Collected	$ 20,601	$ 18,920	$ 42,323	$ 239,372
	Cash and Cash Equivalents	$ 20,572	$ 13,310	$ 20,572	$ 13,310
	Net Working Capital	$ 17,764	$ 8,953	$ 17,764	$ 8,953
	Unrestricted Assets	$ 59,686	$ 27,411	$ 59,686	$ 27,411
	Credit Ratings (S&P, FITCH and Moody's)				

Note: September 2016 YTD is only for the period 8/1-9/30. The prior year YTD is the full fiscal year for FY15

	Saint Mary's Health System (Consolidated)	Month		Year to Date	
		Sept 2016	Prior Year	Sept 2016*	Prior Year
A.	**Operating Performance**				
	Operating Margin	1.3%	-0.1%	-0.4%	0.7%
	Non-Operating Margin	0.1%	-5.0%	0.1%	0.9%
	Total Margin	1.4%	-5.0%	-0.3%	1.6%
	Bad Debt as % of Gross Revenue	0.5%	0.7%	0.9%	1.1%
B.	**Liquidity**				
	Current Ratio	1.65	1.38	1.65	1.38
	Days Cash on Hand	27	19	27	19
	Days in Net Accounts Receivable	37	42	37	42
	Average Payment Period	52	58	52	58
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.01	0.29	0.01	0.28
	Long-term Debt to Capitalization	0.01	0.23	0.01	0.22
	Unrestricted Cash to Debt	24.72	0.98	24.72	0.98
	Times Interest Earned Ratio	37.4	-57.7	(26.30)	3.20
	Debt Service Coverage Ratio	44.4	4.9	7.79	4.33
	Equity Financing Ratio	2.88	4.05	2.88	4.05
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 332	$ (3)	$ (218)	$ 2,161
	Revenue Over/(Under) Expense	$ 373	$ (1,137)	$ (176)	$ 4,689
	EBITDA	$ 1,776	$ 1,240	$ 2,624	$ 14,777
	Patient Cash Collected	$ 23,617	$ 21,477	$ 48,614	$ 272,841
	Cash and Cash Equivalents	$ 22,818	$ 15,091	$ 22,818	$ 15,091
	Net Working Capital	$ 27,488	$ 17,267	$ 27,488	$ 17,267
	Unrestricted Assets	$ 56,272	$ 32,395	$ 56,272	$ 32,395
	Credit Ratings (S&P, FITCH and Moody's)				

Note: September 2016 YTD is only for the period 8/1-9/30. The prior year YTD is the full fiscal year for FY15

Docket Number: 15-31979-CON
Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation
Response to Item 9 of the Settlement and Order dated 8/1/2015
Annual Report for the Capital Investment Plan due 11/30/2016

Question 1

Provide a five-year post-closing capital investment plan detailing the proposed allocation of the $275 million capital investment commitment. The submitted plan shall account for the full $275 million commitment as stated in the proposal and include the following information:

a. A list of planned capital expenditures with detailed descriptions and associated estimated costs, and

Please refer to Attachment 1 for FY 2016 actual capital expenditures for the twelve month period ended September 30, 2016.

Attachment 2 includes the final approved capital budget (see column C) for Trinity Health –New England, Inc. (TH-NE) which has been approved by both Trinity Health's governing body as well as TH-NE's finance committee. The FY 2017 budget is for the period 7/1/2016-6/30/2017.

Attachment 2 has also been updated to reflect preliminary capital budget for FY 2018-2020. TH-NE, including Saint Francis Hospital and Medical Center, is in the process of developing their three to five year strategic plan. Future year's capital expenditures will be further defined and aligned with the outcome of the strategic planning process.

Since our last filing, Saint Mary's Hospital joined Trinity Health-New England. Attachment 2 has also been updated to reflect Saint Mary's FY 2017 routine and strategic capital budget. Furthermore, one critical investment necessary to effectively provide care to members of our community is to implement a single electronic health record across all of the hospitals and ambulatory providers. TH-NE will be investing in this technology at Saint Mary's and has allocated $20.5 million to this project.

b. A timeframe for the rollout of the capital projects, including estimated beginning, ending and start-up/operation dates.

See Attachment 3 for the FY 2017 individual capital projects greater than $500,000 that have been approved to proceed at Saint Francis. The remaining dollars relating to the capital budget will be allocated based upon current priorities and any critical needs that arise.

As the strategic plan is finalized and the more significant capital investments are identified, TH-NE will provide OHCA with an update for this stipulation. Trinity Health – New England, Inc. believes this approach will ensure the greatest accuracy as well as meet the intent of this stipulation.

Updated Capital Expenditure Summary 10/1/2015-9/30/2016

Entity	Service Line	Project Description	Budget	Actual Expenditures
Saint Francis Hospital and Medical Center	Facilities	Trinity Signage Branding	$ 627,000	$ -
Saint Francis Hospital and Medical Center	Facilities	Facilities Gen. - Renoc-Elect.Wholesalers Facility For Parking		$ 878,286
Saint Francis Hospital and Medical Center	Facilities	Gengras 5th Floor Renovations		$ 763,217
Saint Francis Hospital and Medical Center	Women and Infants	Women and Infants Build Out Addition to Women's Center	$ 1,000,000	553,569
Saint Francis Hospital and Medical Center	Facilities	Collins Parking Garage Repairs	$ 750,000	776,371
Saint Francis Hospital and Medical Center	Business Development	Various Construction Projects*	$ 1,000,000	-
Saint Francis Hospital and Medical Center	Cardiovascular	Cath Lab Renovation and Replacement FY16	$ 1,500,000	770,948
Saint Francis Hospital and Medical Center	Facilities	Renovation General - Office Renovations	$ 2,000,000	120,636
Saint Francis Hospital and Medical Center	Facilities	Renovation General - Burgdorf Renovation	$ 800,000	437,271
Saint Francis Hospital and Medical Center	Facilities: Engineering	Medical Office Building Renovations	$ 500,000	161,967
Saint Francis Hospital and Medical Center	Information Technology	Infrastructure Movement and Replacement of Data Center	$ 6,000,000	4,997,817
Saint Francis Hospital and Medical Center	Information Technology	EMC Project-Buid and Archive SFS Data To EMC		747,634
Saint Francis Hospital and Medical Center	Administration	Contingency FY16 Major Items	$ 1,220,229	-
Mount Sinai Hospital	Physical Medicine and Rehabilitation	Vision Center Renovation - Replace Back Center ***	$ 975,550	-
Mount Sinai Hospital	Physical Medicine and Rehabilitation	Replace 800K Absorber	$ 520,000	-
Saint Francis Medical Group	SFMG	Renovation for Rheumatology Bariatrics and Endocrine	$ 1,500,000	93,213
Saint Francis Hospital and Medical Center	CJRI	CJRI TWO O.R.s	$ 1,583,500	1,686,256
Saint Francis Hospital and Medical Center	Information Technology	Epic Ambulatory Implementation	$ 5,164,190	4,206,039
		Total of projects budgeted over $500,000 FY2016	**$ 25,140,469**	**$ 16,193,224**
Saint Francis Hospital and Medical Center	Strategic Investments	Acquisition of Johnson Memorial**	$ 20,015,000	$ 20,015,000
		Total of projects budgeted under $500,000 FY 2016	$ 12,778,531	$ 13,292,542
		Johnson Capital Expenditures		1,496,335
		Total Capital Budget for FY 2016 and Expenditures to Date	**$ 57,934,000**	**$ 50,997,102**
		Capital expenditures specific to Saint Francis	**$ 37,919,000**	**$ 29,485,767**

* Construction budget reduced to $250,000 to reallocate capital to other project
** $18 million funded through an intercompany loan from Trinity Health Corporate

Attachment 2
Preliminary Capital Investment Plan for Saint Francis *Care* , Inc.
Dollars in Thousands

	(a)	(b)	(C)	(d)			
	Five Year Total	Expenditures (10/1/2015-9/30/2016)	FY 2017 Budget (7/1/2016-6/30/2017)	FY 2018 Budget (7/1/2017-6/30/2018)	FY 2019 Budget (7/1/2018-6/30/2019)	FY 2020 Budget (7/1/2019-6/30/2020)	Estimated Five Year Capital Spend
Preliminary capital expenditures summary							
Investment in facilities, medical and non-medical equipment and technology	$ 184,000	21,428	$ 10,355	$ 25,000	$ 20,000	$ 20,000	$ 96,783
Capital leases associated with Epic and other	4,500	1,028	1,300				2,328
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	5,000	3,104	3,000	1,000	1,000		8,104
Expansion/renovations of clinical facilities	10,000		1,500	15,000			16,500
Physician acquisitions/ambulatory network development	23,500		3,200	2,500	2,500	2,500	10,700
Information Technology		3,926					3,926
Unspecified; to be allocated based on organizional priorities each year	48,000	20,015		5,000	10,000	15,000	50,015
							-
Adjustments to preliminary capital expenditure summary:							-
Reallocation to Johnson Memorial - part of strategic growth of RHM		1,496	1,512	3,000	3,000	1,500	10,508
Reallocation to Saint Mary's-part of strategic growth of RHM			20,272	15,000	15,000	20,000	70,272
Saint Mary's Epic Implementation			20,475				20,475
Total estimated annual capital expenditures	$ 275,000	$ 50,997	$ 61,614	$ 66,500	$ 51,500	$ 59,000	$ 289,611

(a) Preliminary plan for capital commitment as noted on page 635 of CON.
(b) Capital expenditures 10/1/2015-9/30/2016 see detail at Attachment 2 (SFHMC and Johnson acquistion)
(C) Budget for FY 2017 reduced due to Trinity Corporate financial objectives. Approved Trinity Health-New England Capital budget for Saint Francis and Johnson was $20,867,000
Saint Mary's routine and strategic capital for FY 2017 is $20,272,000. In addition, the implementation of Epic is $20,475,000 million.
(d) Amounts continue to be preliminary based on evolving RHM strategy and expected investment necessary for Saint Francis facilities and equipment, etc. Strategic plan currently being developed.
$15 million in FY 2018 for expansion of clinical facilities is for an Ambulatory Surgery Center (pending any required approvals and finalization of strategic plan)

Note: $20,015 in FY 2016 was investment in Johnson Memorial Hospital which closed on 1/1/2016

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Stipulation # 9

Attachment 3: Saint Francis Hospital and Medical Center Specific Projects Approved for FY 2017 (7/1/2016-6/30/2017) > $500,000

Project Type	Project Name (50 characters)	Long Description (250 characters)	2017 Budget
Clinical	Replace Beds	Critical Care SL, Department # 71800 - CICU	$ 881,136
IT	Infrastructure - Primary Backup Data Domain / Centera Growth	IT SL, Department # 15130 - IES	$ 600,000
Clinical	Stryker Power Equipment	CJRI SL, Department # 50020 - CJRI OR	$ 1,302,000
Clinical	OMNINAV Robotic Unit	CJRI SL, Department # 50020 - CJRI OR	$ 500,000
Clinical	Tele monitors for Bldg 1 and 2	Tele monitors for Bldg 1 and 2	$ 1,018,000
Furniture, Fixtures & Non-Clinical Equipment	Miscellaneous General - Trinity Signage - 2054	Facilities SL, Engineering Department # 35100	$ 600,000
Facilities	Facilities & Infrastructure	Fairbanks Energy LED: Energy Audit SFHMC, RHHCT, JMMC	$ 766,961
IT	New maintenance management system	New maintenance management system	$ 756,950
IT	IT system	Replacment of the treatment planning system; Pinncle and transition to Raytstation.	$ 500,000
Clinical	Philips Medical System		$ 885,970
Planning, Design & Construction	Renovation of oncology units	Renovate 8-1, 8-1a (donor funded)	$ 2,599,759
Planning, Design & Construction	Renovation of oncology units	Renovate 8-2	$ 675,000
		Sub-total projects >$500,000	**$ 11,085,776.00**

1000 Asylum Street
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November 30, 2016

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410 Capitol Avenue
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P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended September 30, 2016

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost savings opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Interest expense savings for the twelve months ended September 30, 2016 was $2.5 million with $2.0 million being realized in the six month period ended September 30, 2016 due to an interest rate rebate from system office received in June 2016 for approximately $1.0 million.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This was an overall decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. The benefit related to this change was $621,000 for the six month period ended 9/30/2016.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans, Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis

recognized an annual benefit in pension expense of $4.2 million for the twelve month period ended September 30, 2016. For the period from April 1, 2016 to September 30, 2016, the realized benefit was $2.9 million.

Since the last report provide to OHCA on May 31st, Saint Francis transitioned to the Trinity Health Group Purchasing Organization, HPG. This has resulted in supply chain savings of approximately $713,000 for the period April 1, 2016 to September 30, 2016. In addition, Saint Francis received HPG rebates of approximately $214,000 in September 2016. In addition to the pricing benefits realized under the HPG agreement, the Supply Chain leadership has been identifying contracts at Saint Francis that can be shifted to Trinity contracts which will also result in incremental savings in FY 2017.

As Saint Francis benefits from Trinity Health's pricing arrangements with vendors, we have also realized $1.2 million in cost savings for capital information technology relating to Epic hardware in the twelve months ended September 30, 2016. Operating expense savings relating to information technology was $53,000 for the six month period ended September 30, 2016.

There were no cost savings specific to Trinity Health – New England, Inc. (formerly known as Saint Francis *Care*, Inc.) as there are no operating expenses currently within this entity.

Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2016-9/30/2016

LINE	DESCRIPTION	Savings 4/1/2016-9/30/2016 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,921
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$927
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$1,953
H.	Malpractice Insurance Cost	$621
I.	Utilities	
J.	Business Expenses (insurance and IT)	$141
K.	Other Operating Expense	
	Total savings 10/1-3/31	$6,563

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$76,694,000	$22,557,000	($54,137,000)	-71%
2	Short Term Investments	$9,418,000	$33,338,000	$23,920,000	254%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$65,284,000	$67,940,000	$2,656,000	4%
4	Current Assets Whose Use is Limited for Current Liabilities	$1,521,000	$0	($1,521,000)	-100%
5	Due From Affiliates	$4,864,000	$47,485,000	$42,621,000	876%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$9,701,000	$8,912,000	($789,000)	-8%
8	Prepaid Expenses	$8,457,000	$4,378,000	($4,079,000)	-48%
9	Other Current Assets	$2,211,000	$2,134,000	($77,000)	-3%
	Total Current Assets	**$178,150,000**	**$186,744,000**	**$8,594,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$48,893,000	$51,025,000	$2,132,000	4%
2	Board Designated for Capital Acquisition	$26,070,000	$27,789,000	$1,719,000	7%
3	Funds Held in Escrow	$817,000	$0	($817,000)	-100%
4	Other Noncurrent Assets Whose Use is Limited	($1,521,000)	$0	$1,521,000	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$74,259,000**	**$78,814,000**	**$4,555,000**	**6%**
5	Interest in Net Assets of Foundation	$9,394,000	$11,681,000	$2,287,000	24%
6	Long Term Investments	$25,350,000	$20,027,000	($5,323,000)	-21%
7	Other Noncurrent Assets	$7,117,000	$12,802,000	$5,685,000	80%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$873,910,000	$418,811,000	($455,099,000)	-52%
2	Less: Accumulated Depreciation	$427,558,000	$43,734,000	($383,824,000)	-90%
	Property, Plant and Equipment, Net	**$446,352,000**	**$375,077,000**	**($71,275,000)**	**-16%**
3	Construction in Progress	$8,411,000	$14,907,000	$6,496,000	77%
	Total Net Fixed Assets	**$454,763,000**	**$389,984,000**	**($64,779,000)**	**-14%**
	Total Assets	**$749,033,000**	**$700,052,000**	**($48,981,000)**	**-7%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$36,361,000	$24,750,000	($11,611,000)	-32%
2	Salaries, Wages and Payroll Taxes	$33,492,000	$35,638,000	$2,146,000	6%

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$12,528,000	$13,400,000	$872,000	7%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,298,000	$6,926,000	($372,000)	-5%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$6,680,000	$5,962,000	($718,000)	-11%
	Total Current Liabilities	**$96,359,000**	**$86,676,000**	**($9,683,000)**	**-10%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$244,154,000	$237,731,000	($6,423,000)	-3%
2	Notes Payable (Net of Current Portion)	$0	$0	$0	0%
	Total Long Term Debt	**$244,154,000**	**$237,731,000**	**($6,423,000)**	**-3%**
3	Accrued Pension Liability	$234,591,000	$226,613,000	($7,978,000)	-3%
4	Other Long Term Liabilities	$43,991,000	$15,130,000	($28,861,000)	-66%
	Total Long Term Liabilities	**$522,736,000**	**$479,474,000**	**($43,262,000)**	**-8%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$52,342,000	$49,025,000	($3,317,000)	-6%
2	Temporarily Restricted Net Assets	$24,417,000	$29,566,000	$5,149,000	21%
3	Permanently Restricted Net Assets	$53,179,000	$55,311,000	$2,132,000	4%
	Total Net Assets	**$129,938,000**	**$133,902,000**	**$3,964,000**	**3%**
	Total Liabilities and Net Assets	**$749,033,000**	**$700,052,000**	**($48,981,000)**	**-7%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,104,370,392	$2,252,204,000	$147,833,608	7%
2	Less: Allowances	$1,420,599,391	$1,498,710,000	$78,110,609	5%
3	Less: Charity Care	$13,558,599	$8,463,000	($5,095,599)	-38%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$670,212,402**	**$745,031,000**	**$74,818,598**	**11%**
5	Provision for Bad Debts	$20,980,833	$14,575,000	($6,405,833)	-31%
	Net Patient Service Revenue less provision for bad debts	**$649,231,569**	**$730,456,000**	**$81,224,431**	**13%**
6	Other Operating Revenue	$31,281,747	$38,574,000	$7,292,253	23%
7	Net Assets Released from Restrictions	$4,156,122	$3,397,000	($759,122)	-18%
	Total Operating Revenue	**$684,669,438**	**$772,427,000**	**$87,757,562**	**13%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,621,228	$258,412,000	$790,772	0%
2	Fringe Benefits	$68,082,765	$63,421,000	($4,661,765)	-7%
3	Physicians Fees	$47,535,764	$52,062,000	$4,526,236	10%
4	Supplies and Drugs	$99,464,711	$115,390,000	$15,925,289	16%
5	Depreciation and Amortization	$37,713,710	$44,179,000	$6,465,290	17%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$11,151,596	$8,115,000	($3,036,596)	-27%
8	Malpractice Insurance Cost	$10,303,205	$8,753,000	($1,550,205)	-15%
9	Other Operating Expenses	$149,739,353	$211,691,000	$61,951,647	41%
	Total Operating Expenses	**$681,612,332**	**$762,023,000**	**$80,410,668**	**12%**
	Income/(Loss) From Operations	**$3,057,106**	**$10,404,000**	**$7,346,894**	**240%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	($2,527,631)	$6,882,000	$9,409,631	-372%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($17,532,605)	($4,960,000)	$12,572,605	-72%
	Total Non-Operating Revenue	**($20,060,236)**	**$1,922,000**	**$21,982,236**	**-110%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($17,003,130)**	**$12,326,000**	**$29,329,130**	**-172%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($17,003,130)**	**$12,326,000**	**$29,329,130**	**-172%**
	Principal Payments	$8,785,000	$0	($8,785,000)	-100%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$102,071,000	$54,842,000	($47,229,000)	-46%
2	Short Term Investments	$33,496,000	$43,685,000	$10,189,000	30%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$77,445,000	$78,467,000	$1,022,000	1%
4	Current Assets Whose Use is Limited for Current Liabilities	$1,521,000	$0	($1,521,000)	-100%
5	Due From Affiliates	$3,400,000	$30,984,000	$27,584,000	811%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$9,701,000	$8,912,000	($789,000)	-8%
8	Prepaid Expenses	$7,851,000	$4,819,000	($3,032,000)	-39%
9	Other Current Assets	$6,745,000	$5,743,000	($1,002,000)	-15%
	Total Current Assets	**$242,230,000**	**$227,452,000**	**($14,778,000)**	**-6%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$48,894,000	$51,025,000	$2,131,000	4%
2	Board Designated for Capital Acquisition	$27,242,000	$27,789,000	$547,000	2%
3	Funds Held in Escrow	$43,133,000	$0	($43,133,000)	-100%
4	Other Noncurrent Assets Whose Use is Limited	($1,521,000)	$0	$1,521,000	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$117,748,000**	**$78,814,000**	**($38,934,000)**	**-33%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$25,097,000	$22,193,000	($2,904,000)	-12%
7	Other Noncurrent Assets	$15,864,000	$41,494,000	$25,630,000	162%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$912,915,000	$429,833,000	($483,082,000)	-53%
2	Less: Accumulated Depreciation	$454,078,000	$45,381,000	($408,697,000)	($1)
	Property, Plant and Equipment, Net	**$458,837,000**	**$384,452,000**	**($74,385,000)**	**-16%**
3	Construction in Progress	$8,411,000	$14,931,000	$6,520,000	78%
	Total Net Fixed Assets	**$467,248,000**	**$399,383,000**	**($67,865,000)**	**-15%**
	Total Assets	**$868,187,000**	**$769,336,000**	**($98,851,000)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$41,686,000	$30,149,000	($11,537,000)	-28%
2	Salaries, Wages and Payroll Taxes	$51,151,000	$57,548,000	$6,397,000	13%
3	Due To Third Party Payers	$13,630,000	$15,584,000	$1,954,000	14%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,298,000	$7,292,000	($6,000)	0%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$8,658,000	$6,583,000	($2,075,000)	-24%
	Total Current Liabilities	**$122,423,000**	**$117,156,000**	**($5,267,000)**	**-4%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$244,154,000	$255,276,000	$11,122,000	5%
2	Notes Payable (Net of Current Portion)	$0	$0	$0	0%
	Total Long Term Debt	**$244,154,000**	**$255,276,000**	**$11,122,000**	**5%**
3	Accrued Pension Liability	$276,965,000	$230,820,000	($46,145,000)	-17%
4	Other Long Term Liabilities	$43,991,000	$18,208,000	($25,783,000)	-59%
	Total Long Term Liabilities	**$565,110,000**	**$504,304,000**	**($60,806,000)**	**-11%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$101,295,000	$61,336,000	($39,959,000)	-39%
2	Temporarily Restricted Net Assets	$26,180,000	$31,229,000	$5,049,000	19%
3	Permanently Restricted Net Assets	$53,179,000	$55,311,000	$2,132,000	4%
	Total Net Assets	**$180,654,000**	**$147,876,000**	**($32,778,000)**	**-18%**
	Total Liabilities and Net Assets	**$868,187,000**	**$769,336,000**	**($98,851,000)**	**-11%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,433,798,000	$2,622,172,000	$188,374,000	8%
2	Less: Allowances	$1,621,115,000	$1,728,774,000	$107,659,000	7%
3	Less: Charity Care	$14,331,000	$9,009,000	($5,322,000)	-37%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$798,352,000**	**$884,389,000**	**$86,037,000**	**11%**
5	Provision for Bad Debts	$25,600,000	$18,334,000	($7,266,000)	-28%
	Net Patient Service Revenue less provision for bad debts	**$772,752,000**	**$866,055,000**	**$93,303,000**	**12%**
6	Other Operating Revenue	$38,303,000	$49,826,000	$11,523,000	30%
7	Net Assets Released from Restrictions	$10,911,000	$7,952,000	($2,959,000)	-27%
	Total Operating Revenue	**$821,966,000**	**$923,833,000**	**$101,867,000**	**12%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$378,595,000	$402,540,000	$23,945,000	6%
2	Fringe Benefits	$86,980,000	$86,331,000	($649,000)	-1%
3	Physicians Fees	$24,836,000	$28,805,000	$3,969,000	16%
4	Supplies and Drugs	$119,805,000	$137,840,000	$18,035,000	15%
5	Depreciation and Amortization	$39,696,000	$45,487,000	$5,791,000	15%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$11,152,000	$8,116,000	($3,036,000)	-27%
8	Malpractice Insurance Cost	$6,887,000	$12,151,000	$5,264,000	76%
9	Other Operating Expenses	$148,043,000	$201,439,000	$53,396,000	36%
	Total Operating Expenses	**$815,994,000**	**$922,709,000**	**$106,715,000**	**13%**
	Income/(Loss) From Operations	**$5,972,000**	**$1,124,000**	**($4,848,000)**	**-81%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	($2,530,000)	$5,904,000	$8,434,000	-333%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($17,533,000)	($4,960,000)	$12,573,000	-72%
	Total Non-Operating Revenue	**($20,063,000)**	**$944,000**	**$21,007,000**	**-105%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($14,091,000)**	**$2,068,000**	**$16,159,000**	**-115%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$58,589,000	$58,589,000	0%
	Total Other Adjustments	**$0**	**$58,589,000**	**$58,589,000**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($14,091,000)**	**$60,657,000**	**$74,748,000**	**-530%**

TRINITY HEALTH - NEW ENGLAND, INC.
(FORMERLY SAINT FRANCIS *CARE* , INC.)
CONSOLIDATED STATEMENT OF CASH FLOW

		Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$**	**60,657,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**45,487,000**
Bad debts		**18,334,000**
Increase in assets held in trust by others		**(2,131,000)**
Increase in accrued pension liability		**(46,145,000)**
Decrease in other long term liabilities		**(25,783,000)**
Purchase accounting		**(30,319,000)**
Transfer of swap to TH-NE		**(44,000,000)**
Other changes in net assets		**(19,116,000)**
Change in working capital, other than cash and cash equivalents		**(45,857,000)**
Net cash used in operating activities		**(88,873,000)**
Investing activities		
Purchase of property, plant and equipment, net		**(36,317,000)**
Purchase accounting, property, plant and equipment		**58,695,000**
Increase in investments		**(7,285,000)**
Increase in other noncurrent assets		**(25,630,000)**
Decrease in noncurrent assets whose use is limited		**41,065,000**
Net cash used in investing activities		**30,528,000**
Financing activities		
Issuance of long term debt		**18,000,000**
Principal payments on long-term debt		**(6,884,000)**
Net cash provided by financing activities		**11,116,000**
Net decrease in cash and cash equivalents		**(47,229,000)**
Cash and cash equivalents at beginning of period		**102,071,000**
Cash and cash equivalents at end of period	**$**	**54,842,000**

(FORMERLY SAINT FRANCIS *CARE* , INC.)
CONSOLIDATED STATEMENT OF CHANGES IN
COMPONENTS OF WORKING CAPITAL OTHER THAN
CASH AND CASH EQUIVALENTS

		Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$**	**1,521,000**
Accounts receivable--patients, net		**(19,356,000)**
Other current assets		**1,002,000**
Inventory of supplies		**789,000**
Prepaid expenses		**3,032,000**
Due from affiliated entities		**(27,584,000)**
		(40,596,000)
Changes in current liabilities:		
Accounts payable		**(11,537,000)**
Salary and wages, payroll taxes and amounts withheld from employees		**6,397,000**
Other current liabilities		**(2,075,000)**
Due to third party reimbursement agencies		**1,954,000**
		(5,261,000)
Changes in working capital other than cash and cash equivalents	**$**	**(45,857,000)**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

		Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$**	**12,326,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**44,179,000**
Bad debts		**14,575,000**
Increase in interest in Saint Francis Hospital and Medical Center Foundation		**(2,287,000)**
Increase in assets held in trust by others		**(2,132,000)**
Increase in accrued pension liability		**(7,978,000)**
Decrease in other long term liabilities		**(28,861,000)**
Other changes in net assets		**(8,362,000)**
Change in working capital, other than cash and cash equivalents		**(62,697,000)**
Net cash used in operating activities		**(41,237,000)**
Investing activities		
Purchase of property, plant and equipment, net		**(34,704,000)**
Purchase accounting, property, plant and equipment		**55,304,000**
Increase in investments		**(18,597,000)**
Increase in other noncurrent assets		**(5,685,000)**
Increase in noncurrent assets whose use is limited		**(2,423,000)**
Net cash used in investing activities		**(6,105,000)**
Financing activities		
Principal payments on long-term debt		**(6,795,000)**
Net cash used in financing activities		**(6,795,000)**
Net decrease in cash and cash equivalents		**(54,137,000)**
Cash and cash equivalents at beginning of period		**76,694,000**
Cash and cash equivalents at end of period	**$**	**22,557,000**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2016
Changes in current assets:	
Assets whose use is limited required for current liabilities	**$ 1,521,000**
Accounts receivable--patients, net	**(17,231,000)**
Other current assets	**77,000**
Inventory of supplies	**789,000**
Prepaid expenses	**4,079,000**
Due from affiliated entities	**(42,621,000)**
	(53,386,000)
Changes in current liabilities:	
Accounts payable	**(11,611,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**2,146,000**
Accrued expenses and interest payable	**(718,000)**
Due to third party reimbursement agencies	**872,000**
	(9,311,000)
Changes in working capital other than cash and cash equivalents	**$ (62,697,000)**

Attachment C

Saint Francis Hospital and Medical Center

	Sept 16 YTD	Sept 15 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.3%	0.4%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	8.1%	7.6%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.6%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.2	1.8	current assets/current liabilites
Days Cash on Hand	42.6	63.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	33.9	36.7	net ar/net patient ser rev(after bd)/days in yr
Average Payment Period	44.1	54.6	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	182.7%	193.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization	64.0%	65.3%	LTD/LTD+net assets
Unrestricted Cash to Debt	34.2%	44.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.3	1.3	EBIT/Interest expense
Debt Service Coverage Ratio	4.2 x	2.8 x	(Net income+int+depr)/(st debt+int exp)
Equity Financing Ratio	19.1%	17.3%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 10,404	$ 3,057	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 12,326	$ (17,003)	Net gain(loss)
EBITDA	$ 62,698	$ 51,923	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 55,895	$ 86,112	from cons bs
Net Working Capital	$ 100,068	$ 81,791	current assets-current liabilities
Unrestricted Assets	$ 49,025	$ 52,342	from cons bs

Attachment C

Trinity Health - New England (Hartford)

		Sept 16 YTD		Sept 15 YTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin		0.1%		0.7%	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		5.9%		6.9%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		0.7%		1.1%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		1.9		2.0	current assets/current liabilites
Days Cash on Hand		52.6		76.5	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables		33.1		36.6	net ar/net patient ser rev/days in yr
Average Payment Period		48.7		57.6	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		177.6%		139.2%	total debt/total equity(net assets)
Long-term Debt to Capitalization		63.3%		57.5%	LTD/LTD+net assets
Unrestricted Cash to Debt		0.5		0.6	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		1.1		1.5	EBIT/Interest expense
Debt Service Coverage Ratio		3.6 x		3.1 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		19.2%		20.8%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations	$	1,124	$	5,972	Net income(loss) from operations
Revenue Over/(Under) Expense	$	60,657 *	$	(14,091)	Net gain(loss)
EBITDA	$	54,727	$	56,820	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	98,527	$	135,567	from cons bs
Net Working Capital	$	110,296	$	119,807	current assets-current liabilities
Unrestricted Assets	$	61,336	$	101,295	from cons bs

* includes puchase accounting goodwill adjustment

Attachment C

Trinity Health - New England (Hartford)

	Sept 16 YTD	Sept 15 YTD	Explanation
D. Additional Statistics			YTD net patient revenue increased $93.3M, Operating expenses increased $106.7M due to costs of drugs and medical supplies, professional fees for EPIC support, merger due diligence, JMMC acquisition and purchase accounting including
Income(Loss) from Operations	1,124	5,972	depreciation and SFMG's increased loss of ($5.4M).
Revenue Over/(Under) Expense	60,657	(14,091)	Purchase accounting goodwill adjustment of $58.6 million. Swap activity of $15.5M for year end Sept 2015. SWAP transferred on 10/1 to Trinity Health.
EBITDA	54,727	56,820	YTD net patient revenue increased $93.3M, Operating expenses increased $106.7M due to costs of drugs and medical supplies, professional fees for EPIC support, merger due diligence, JMMC acquisition and purchase accounting including depreciation and SFMG's increased loss of ($5.4M).
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	98,527	135,567	Decrease in a/p ($11.5M); increase in due from affiliates $27.5M; funds expended for tail liablility $8.5M; JMMC purchase $2.3M; SWAP and debt termination expenses.
Net Working Capital	110,296	119,807	Decrease in cash and cash equivalents ($37M), decrease in a/p ($11.5M).
Unrestricted Assets	61,336	101,295	Change in PPE ($74M) due to purchase accounting adjustments; Increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Saint Francis Hospital

	Sept 16 YTD	Sept 15 YTD	
D. Additional Statistics			YTD net patient revenue increased $87M. Operating expenses increased $80M due to costs of drugs and medical supplies,
Income(Loss) from Operations	10,404	3,057	professional fees for EPIC support, nurse registry fees, merger due diligence, JMMC acquisiton and purchase accounting adjustments including depreciation.
Revenue Over/(Under) Expense	12,326	(17,003)	Swap activity of ($15.5M) for year end Sept 2015. SWAP transferred on 10/1 to Trinity Health.
EBITDA	62,698	51,923	YTD net patient revenue increased $87M. Operating expenses increased $80M due to costs of drugs and medical supplies, professional fees for EPIC support, nurse registry fees, merger due diligence, JMMC acquisiton and purchase accounting adjustments including depreciation.
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	55,895	86,112	Decrease in a/p ($11.6M), increase in due from affiliates $42.6M
Net Working Capital	100,068	81,791	Decrease in cash and cash equivelents ($30M), decrease in a/p ($11.6M), increase in due from affiliates $42.6M.
Unrestricted Assets	49,025	52,342	YTD income $10.4M; Change in PPE ($71M) due to purchase accounting adjustments; Increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Mrs. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Item #9 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to JMMC and JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

> *a) A list of planned capital expenditures with detailed descriptions and associated estimated costs; and b) A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and c) Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by JMMC's Chief Financial Officer.*

Since the approval of the Certificate of Need, Johnson has been in the process of developing the capital budget for FY 2017 (July 1, 2016 through June 30, 2017).

For the period April 1, 2016 through September 30, 2016, Johnson incurred capital expenditures of $1.1 million (See **Attachment A**). As previously reported, Trinity Health – New England (formerly known as Saint Francis *Care,* Inc.*)* and Johnson accelerated the timing of the implementation of the Epic electronic medical record system. The total capital cost of this system implementation relating to Johnson was approximately $6.8 million, which was paid by Saint Francis Hospital and Medical Center and ultimately structured as a capital lease to Johnson. Annual capital lease payments from Johnson to Saint Francis Hospital and Medical Center total $960,000 annually for seven years, $480,000 for the six month period ended September 30, which has been included in the capital expenditure report attached.

The FY 2017-FY2020 preliminary capital budget for Johnson (see **Attachment B**) was developed as part of the Trinity Health-New England's capital and operating budget processes as well as the current strategic financial planning process for the fiscal years 2018-2020. While capital projects are inventoried and identified during the strategic planning process, the actual expenditure for FY 2017, 2018 and 2019 will likely be $1.5 million, $3.0 million and $3.0 million, respectively. Individual items on Johnson's capital request will be continuously evaluated as we are constantly assessing the strategic needs of the facilities.

Johnson Memorial Hospital/Johnson Memorial Medical Center
New Acquisition Jan - Sept 16
Stipulation # 9 Attachment A

Row Labels	Sum of ORIGINAL COST
1/1/2016	**$ 102,509**
AccuDose Door Lock	$ 50,603
MRI Portico work	$ 31,904
software	$ 13,053
(blank)	$ 6,949
2/1/2016	**$ 40,656**
HD LED CD monitor/stand/basket	$ 14,260
JSC humidity & temp control	$ 26,396
3/1/2016	**$ 43,475**
AccuDose Door Lock	$ 7,425
analog video monitor syste -icu	$ 4,987
Endo cleaning station	$ 7,312
JSC humidity & temp control	$ 4,695
pneumatic Tube system	$ 10,276
upgrad to hum/temp controls	$ 8,780
4/1/2016	**$ 55,385**
Anesthesia monitors- lease buyout	$ 12,000
Psych room renovations	$ 19,825
renov for steris washer/sink,counter	$ 11,900
Steris/Amsco Washer	$ 11,660
5/1/2016	**$ 111,352**
Centricity Perinatal Intrapartum System	$ 86,343
Cystoscope equipment	$ 25,009
6/1/2016	**$ 279,465**
EPIQ 7G Ultrasound System	$ 259,640
Psych room renovations	$ 19,825
7/1/2016	**$ 23,496**
Endo cleaning station	$ 17,061
LF-DP Tracheal Intubation Fib rscope	$ 6,435
8/1/2016	**$ 119,998**
Kawneed series alum doors	$ 7,750
PeopleSoft Licenses	$ 112,248
Grand Total	**$ 776,335**

Epic Capital Lease	$	720,000
Total Capital Expenditures including Lease 1/1-9/30	$	1,496,335
Total Capital Expenditures including Lease 4/1-9/30	$	1,069,696

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Plant Operations (8060)	Electrical upgrades - Phase One (FY18= $600k, FY19=$100k)	1		460,909	239,091		
Plant Operations (8060)	Kitchen Exhaust System	1		235,797			
Radiology (7240)	Digital Radiology room - remove old equip, install	1	R	210,000			
Nursing Admin (6010)	R Series ALC biphasic ZOLL Defibrillators (11 defibrillators)	1	R	208,611			
Plant Operations (8060)	Paving Visitor Parking Lot	2	R	126,165			
Plant Operations (8060)	Patient Room windows - recalk for blurry			50,000			
Pharmacy (7330)	Guardrails Service contract for Alaris IV pumps	1	R	72,000			
Plant Operations (8060)	Repairs to main Entrance Canopy	1		65,418			
Plant Operations (8060)	Uranium System	1		35,000			
Radiology (7240)	Raometeric - one for JSC & JMH	1	N	18,000			
Pharmacy (7330)	3-card reader controller Locks (2 Stfd, 1 Enf)	1	N	10,000			
Plant Operations (8060)	Remove & install new Fire Hydrant	1		8,100			
Pharmacy (7330)	IV room @ JMH	1	N		500,000		
Radiology (7240)	Digital Mammography upgrad 2D @ JSC and Digital @JMH	1	R		430,000		
Radiology (7240)	R&F Digital room - remove old equip, install	1	R		$369,750		
Pharmacy (7330)	AcuDose Equipment for OR suites @ JSC OR suites	1	N	-	274,001		
Radiology (7240)	GE OEC C-Arm	2	R		200,000		
Ultrasound (7280)	Ultrasound room & removal of old u/s equip	1	R		135,395		
Ultrasound (7280)	Philips EPIQ 7 Diamond Select System	1	R		118,000		
Plant Operations (8060)	Boiler,Energy Saving Controls/Hawk system	1	R		125,915		
Plant Operations (8060)	Paving Roadway, Loading Dock area, parking	2	R		$122,841		
Pharmacy (7330)	AcuDose Software Upgrade Connect	1	R		76,118		
Nursing Admin (6010)	Carefusion Alaris PCA modules, Unites, ETC02 modules	1	R		75,768		
Cardiolvascular (7250)	Cardiovascular Ultrasound Scanner	1	R		75,150		
Plant Operations (8060)	Bobcat for Snow removal & grounds work	2			$70,000		
Central Sterile Proc. (6760)	Getinge 733 sterilizer	1	N		69,636		
JSC (Surgery Ctr) (6600)	OR Surgical Lights in OR 1, 2 & 3	1	R		66,492		
Plant Operations (8060)	ABS - JMH OR/Pharmacy/Heat Exchanger	2			61,320		
Plant Operations (8060)	Lighting Protections: Main Bldg; BH; PH; & WWTP	2			$55,550		
Plant Operations (8060)	Truck	2			50,000		

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
JSC (Surgery Ctr) (6600)	Stryker Video Equipment Incl display & camera heads	2	R		40,101		
Enfield Phys Med (7093)	Mediware MediLinks OP CUL License	1	N		39,960		
Perioperative Svcs (6610)	Urology Instrumentation	1	R		34,000		
Nursing Admin (6010)	Carefusion Alaris syringe modules and software	2	R		33,252		
Nursing Admin (6010)	3 EZZ way 1000 lb ceiling lifts w continuous charge	2	N		32,262		
Plant Operations (8060)	Paint Boiler House Smoke Stack	2			$31,180		
Psychiatry (6070)	Psychiatric Safe Medical Beds - 5 beds @ $5,900	2	N		29,500		
CT Scan (7230)	ACR CT phantoms for JSC & JMH	1	N		26,000		
Plant Operations (8060)	I-Net Sysetm Upgrade	1			13,285		
Pharmacy (7330)	Camera Security System for pharm (4 Stfd, 2 Enf)	1	N		12,000		
Plant Operations (8060)	Fleet Guard Key System - control system	2			11,818		
Radiology (7240)	Stryker Stretcher - trauma - JMH	1	R		$9,100		
Plant Operations (8060)	Backup Myers Pump for Bed 6 WWTP	2			9,084		
Ultrasound (7280)	Stryker OB Stretcher for JSC	1	N		6,000		
Plant Operations (8060)	Install 9 bollards in front of Generator	1			$7,786		
	Carefusion					2,000,000	
	Pixis						
Nuclear Medicine (7300)	Siemens Symbia T6 Spect/CT camera	1	R			599,600	
CT Scan (7230)	Siemens Somatome Perspective 64 slice scanner	1	R			525,000	
Radiology (7240)	RadSpeed Auto Dr Radiographic Room	2	R			273,350	
Laboratory (7020)	Hematology replacemsnt (2) Sysmex XN2000 analyzers	2	R			173,918	
Same Day Surgury (6605)	GE patient monitors & Central station monitor	2	R			145,834	
Plant Operations (8060)	Hot Water System	3				130,000	
Laboratory (7020)	(2) ACL TOP 300 Coagulation analyzers	1	R			90,000	
Perioperative Svcs (6610)	Mammotome	1	N			$65,526	
Radiology (7240)	Bone Density (remove old equip, install)	3	R			65,000	
Central Sterile Proc. (6760)	Getinge 8668 Washer Disinfecter 12 Tray unit	3	N			55,598	
Plant Operations (8060)	Fuel duplex pump set	3				47,919	
Plant Operations (8060)	Medical Vacuum System	3				$31,997	
Respiratory Therapy (7400)	Maquet SERVO - 1 Universal Core	1	N			30,681	

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Cardiac Rehab (7590)	complete phase 3 of business plan for relocation	1	N			23,100	
Radiology (7240)	C-Arm Table	3	R			20,000	
Plant Operations (8060)	New Well Install #9 - LaFamboise	3				17,155	
Anesthesia (7370)	Glide Scope	1	R			$14,422	
CT Scan (7230)	Renovation of Ct area - stretcher, curtain, paint/floor		R			10,000	
Radiology (7240)	renovation of main xray viewing room		N			10,000	
Emergency Rm (6850)	Stryker Stretcher - Trauma/2 Big Wheel	1	N			9,405	
Post Anesthesia Care (6660	Transport Monitor	1	N	-		8,530	
Laboratory (7020)	Ortho Workstation for ID-MTS Gel Cards	1	N			7,060	
Central Sterile Proc. (6760)	Getinge Prep & Pack table	3	N			6,883	
Enfield Phys Med (7093)	NuStep Recumbent Cross Trainer w/oversized seat	2	R			6,670	
Laboratory (7020)	Hematology micro scope	1	R			$6,400	
CT Scan (7230)	Countertop Blanket Warmer		N			6,000	
Radiology (7240)	GE 9" Laser Aimer for OEC 9899 +C-Arm Part		N			6,000	
Enfield Phys Med (7093)	AC5000M Treadmill w handrails/wght cap of 550 lbs	3	R			4,972	
CT Scan (7230)	64 slice Ct Scanner with install & remove old equip,	2	R				$569,170
Plant Operations (8060)	Contingency - Emergency Repairs	3					500,000
Anesthesia (7370)	Anesthisia Machines	3	R				400,000
Plant Operations (8060)	Nirenberg - Generators	3					350,000
Grand Totals JMMC				$ 1,500,000	$ 3,450,355	$ 4,391,020	$ 1,819,170

Note: Based on current infrastructure issues at Johnson, the creation of a sewer system is expected over the next three years. The estimated costs for Johnson relating to this project is approximately $4.0 million. This amount is not included in the schedule above.

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Mrs. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2016

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health – New England, Inc. In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $49,000 for the six month period ended September 30, 2016.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million with savings realized for the six month period ended September 30, 2016 of $496,000, exclusive of one time tail coverage costs incurred as part of the transaction.

There have been significant efforts to centralize support functions across Trinity Health-New England including Finance, Revenue Cycle, and Information Systems. This has resulted in reduction of costs at Johnson of $315,000 for the six months ended September 30, 2016.

In addition, Johnson has benefited from the utilization of regional Legal Services and Compliance and Audit departments. The decrease in legal and auditing costs associated with this transition were $258,000 for the six month period ended September 30, 2016.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health-New England and Trinity Health in each of the areas identified above.

The above savings are offset by a regional allocation of $319,000 for the six month period included in other operating expenses in **Attachment A.**

Interest and insurance savings related to JMMC are included in the amounts described above. There are no additional cost savings within JMMC.

In addition to the synergies realized to date, Johnson is in the process of transitioning to the Trinity Total Rewards program for employee compensation and benefits. Johnson provided its employees with a 2% pay increase on September 1st. This was the first across the board, cost of living increase that Johnson has been able to give its employees since 2008. In addition, effective 1/1/2017, Johnson employees will be participating in Trinity Health's defined contribution plan which provides for a core employer contribution for all employees and matching contributions funded bi-weekly for those employees who make deferrals into the plan.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. These cost savings will be reported when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining Trinity Health – New England, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. Areas of clinical quality improvement have been in decreased Sepsis rates, decreased readmission rates and notices of serious safety events were marginal.

Also, Johnson's average daily census during the months of September and October have been two of the higher months since prior to filing for bankruptcy.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The

required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2016-9/30/2016

LINE	DESCRIPTION	Savings 4/1/2016-9/30/2016 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$315
B.	Fringe Benefits (workers comp)	$101
C.	Contractual Labor Fees	$0
D.	Medical Supplies and Pharmaceutical Cost	$30
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$49
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$395
K.	Other Operating Expense	($61)
	Total savings 1/1-3/31	$829

JOHNSON MEMORIAL HOSPITAL					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
LINE	DESCRIPTION	FY 2015 ACTUAL	FY 2016 SEPTEMBER	AMOUNT DIFFERENCE	% DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,675,853	$0	($1,675,853)	-100%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$9,554,938	$0	($9,554,938)	-100%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,506,354	$0	($1,506,354)	-100%
8	Prepaid Expenses	$1,497,131	$0	($1,497,131)	-100%
9	Other Current Assets	$329,908	$0	($329,908)	-100%
	Total Current Assets	**$14,564,184**	**$0**	**($14,564,184)**	**-100%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$3,425,921	$0	($3,425,921)	-100%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$224,917	$0	($224,917)	-100%
4	Other Noncurrent Assets Whose Use is Limited	$843,587	$0	($843,587)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$4,494,425**	**$0**	**($4,494,425)**	**-100%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,467,074	$0	($3,467,074)	-100%
7	Other Noncurrent Assets	$8,986,456	$0	($8,986,456)	-100%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$66,495,422	$0	($66,495,422)	-100%
2	Less: Accumulated Depreciation	$45,821,926	$0	($45,821,926)	-100%
	Property, Plant and Equipment, Net	**$20,673,496**	**$0**	**($20,673,496)**	**-100%**
3	Construction in Progress	$0	$0	$0	0%
	Total Net Fixed Assets	**$20,673,496**	**$0**	**($20,673,496)**	**-100%**
	Total Assets	**$52,185,635**	**$0**	**($52,185,635)**	**-100%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$8,861,782	$0	($8,861,782)	-100%
2	Salaries, Wages and Payroll Taxes	$1,895,078	$0	($1,895,078)	-100%

JOHNSON MEMORIAL HOSPITAL					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$2,212,362	$0	($2,212,362)	-100%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$11,987,500	$0	($11,987,500)	-100%
6	Current Portion of Notes Payable	$838,274	$0	($838,274)	-100%
7	Other Current Liabilities	$10,142,734	$0	($10,142,734)	-100%
	Total Current Liabilities	**$35,937,730**	**$0**	**($35,937,730)**	**-100%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$4,572,057	$0	($4,572,057)	-100%
	Total Long Term Debt	**$4,572,057**	**$0**	**($4,572,057)**	**-100%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$7,433,424	$0	($7,433,424)	-100%
	Total Long Term Liabilities	**$12,005,481**	**$0**	**($12,005,481)**	**-100%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($498,600)	$0	$498,600	-100%
2	Temporarily Restricted Net Assets	$471,516	$0	($471,516)	-100%
3	Permanently Restricted Net Assets	$4,269,508	$0	($4,269,508)	-100%
	Total Net Assets	**$4,242,424**	**$0**	**($4,242,424)**	**-100%**
	Total Liabilities and Net Assets	**$52,185,635**	**$0**	**($52,185,635)**	**-100%**

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	JAN - SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$171,319,321	$0	($171,319,321)	-100%
2	Less: Allowances	$102,596,531	$0	($102,596,531)	-100%
3	Less: Charity Care	$221,056	$0	($221,056)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$68,501,734**	**$0**	**($68,501,734)**	**-100%**
5	Provision for Bad Debts	$3,114,000	$0	($3,114,000)	-100%
	Net Patient Service Revenue less provision for bad debts	**$65,387,734**	**$0**	**($65,387,734)**	**-100%**
6	Other Operating Revenue	$590,810	$0	($590,810)	-100%
7	Net Assets Released from Restrictions	$23,905	$0	($23,905)	-100%
	Total Operating Revenue	**$66,002,449**	**$0**	**($66,002,449)**	**-100%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$24,833,219	$0	($24,833,219)	-100%
2	Fringe Benefits	$6,111,895	$0	($6,111,895)	-100%
3	Physicians Fees	$4,050,496	$0	($4,050,496)	-100%
4	Supplies and Drugs	$10,665,670	$0	($10,665,670)	-100%
5	Depreciation and Amortization	$1,804,654	$0	($1,804,654)	-100%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$975,626	$0	($975,626)	-100%
8	Malpractice Insurance Cost	$1,058,521	$0	($1,058,521)	-100%
9	Other Operating Expenses	$20,739,982	$0	($20,739,982)	-100%
	Total Operating Expenses	**$70,240,063**	**$0**	**($70,240,063)**	**-100%**
	Income/(Loss) From Operations	**($4,237,614)**	**$0**	**$4,237,614**	**-100%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$228,556	$0	($228,556)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$0	$0	$0	0%
	Total Non-Operating Revenue	**$228,556**	**$0**	**($228,556)**	**-100%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($4,009,058)**	**$0**	**$4,009,058**	**-100%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($4,009,058)**	**$0**	**$4,009,058**	**-100%**
	Principal Payments	$184,222	$0	($184,222)	-100%

JOHNSON MEMORIAL MEDICAL CENTER, INC.

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,805,602	$0	($1,805,602)	-100%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$12,246,951	$0	($12,246,951)	-100%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,523,756	$0	($1,523,756)	-100%
8	Prepaid Expenses	$1,880,119	$0	($1,880,119)	-100%
9	Other Current Assets	$537,387	$0	($537,387)	-100%
	Total Current Assets	**$17,993,815**	**$0**	**($17,993,815)**	**-100%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$4,452,119	$0	($4,452,119)	-100%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$224,917	$0	($224,917)	-100%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$4,677,036**	**$0**	**($4,677,036)**	**-100%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,467,074	$0	($3,467,074)	-100%
7	Other Noncurrent Assets	$1,486,054	$0	($1,486,054)	-100%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$97,485,005	$0	($97,485,005)	-100%
2	Less: Accumulated Depreciation	$70,147,136	$0	($70,147,136)	($1)
	Property, Plant and Equipment, Net	**$27,337,869**	**$0**	**($27,337,869)**	**-100%**
3	Construction in Progress	$0	$0	$0	0%
	Total Net Fixed Assets	**$27,337,869**	**$0**	**($27,337,869)**	**-100%**
	Total Assets	**$54,961,848**	**$0**	**($54,961,848)**	**-100%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

JOHNSON MEMORIAL MEDICAL CENTER, INC.

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$12,652,911	$0	($12,652,911)	-100%
2	Salaries, Wages and Payroll Taxes	$2,677,952	$0	($2,677,952)	-100%
3	Due To Third Party Payers	$2,446,731	$0	($2,446,731)	-100%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$29,141,197	$0	($29,141,197)	-100%
6	Current Portion of Notes Payable	$838,274	$0	($838,274)	-100%
7	Other Current Liabilities	$11,243,011	$0	($11,243,011)	-100%
	Total Current Liabilities	**$59,000,076**	**$0**	**($59,000,076)**	**-100%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$4,572,057	$0	($4,572,057)	-100%
	Total Long Term Debt	**$4,572,057**	**$0**	**($4,572,057)**	**-100%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$4,932,692	$0	($4,932,692)	-100%
	Total Long Term Liabilities	**$9,504,749**	**$0**	**($9,504,749)**	**-100%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($18,535,995)	$0	$18,535,995	-100%
2	Temporarily Restricted Net Assets	$553,275	$0	($553,275)	-100%
3	Permanently Restricted Net Assets	$4,439,743	$0	($4,439,743)	-100%
	Total Net Assets	**($13,542,977)**	**$0**	**$13,542,977**	**-100%**
	Total Liabilities and Net Assets	**$54,961,848**	**$0**	**($54,961,848)**	**-100%**

JOHNSON MEMORIAL MEDICAL CENTER, INC.					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	JAN - SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$206,688,056	$0	($206,688,056)	-100%
2	Less: Allowances	$113,763,631	$0	($113,763,631)	-100%
3	Less: Charity Care	$221,056	$0	($221,056)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$92,703,369**	**$0**	**($92,703,369)**	**-100%**
5	Provision for Bad Debts	$3,470,135	$0	($3,470,135)	-100%
	Net Patient Service Revenue less provision for bad debts	**$89,233,234**	**$0**	**($89,233,234)**	**-100%**
6	Other Operating Revenue	$1,190,422	$0	($1,190,422)	-100%
7	Net Assets Released from Restrictions	$36,593	$0	($36,593)	-100%
	Total Operating Revenue	**$90,460,249**	**$0**	**($90,460,249)**	**-100%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$40,500,652	$0	($40,500,652)	-100%
2	Fringe Benefits	$10,064,877	$0	($10,064,877)	-100%
3	Physicians Fees	$4,050,496	$0	($4,050,496)	-100%
4	Supplies and Drugs	$12,485,965	$0	($12,485,965)	-100%
5	Depreciation and Amortization	$2,419,144	$0	($2,419,144)	-100%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$1,503,067	$0	($1,503,067)	-100%
8	Malpractice Insurance Cost	$1,056,331	$0	($1,056,331)	-100%
9	Other Operating Expenses	$25,211,129	$0	($25,211,129)	-100%
	Total Operating Expenses	**$97,291,661**	**$0**	**($97,291,661)**	**-100%**
	Income/(Loss) From Operations	**($6,831,412)**	**$0**	**$6,831,412**	**-100%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$159,517	$0	($159,517)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$69,138	$0	($69,138)	-100%
	Total Non-Operating Revenue	**$228,655**	**$0**	**($228,655)**	**-100%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($6,602,757)**	**$0**	**$6,602,757**	**-100%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($6,602,757)**	**$0**	**$6,602,757**	**-100%**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

		Nine months ended September 30, 2016
Operating activities and non-operating income		
Deficiency of revenues over expenses	**$**	**(3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**2,481,154**
Bad debts		**3,183,064**
Increase in pension and other accrued expenses		**801,386**
Other changes in net assets		**96,063**
Change in working capital, other than cash and cash equivalents		**2,513,860**
Net cash provided by operating activities		**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net		**(1,679,032)**
Decrease in long term investments		**269,872**
Increase in other assets		**(798,396)**
Net cash used in investing activities		**(2,207,556)**
Financing activities		
Principal payments on long-term debt		**(819,824)**
Net cash used in financing activities		**(819,824)**
Net increase in cash and cash equivalents		**2,059,069**
Cash and cash equivalents at beginning of period		**-**
Cash and cash equivalents at end of period	**$**	**2,059,069**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

		Nine months ended September 30, 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$**	**208,225**
Accounts receivable--patients, net		**(13,228,768)**
Other current assets		**(3,413,454)**
Inventory of supplies		**63,398**
Prepaid expenses		**719,973**
		(15,650,626)
Changes in current liabilities:		
Accounts payable		**(4,509,604)**
Salary and wages, payroll taxes and amounts withheld from employees		**1,886,309**
Due to affiliates		**22,551,291**
Other current liabilities		**(573,651)**
Due to third party reimbursement agencies		**(1,189,859)**
		18,164,486
Changes in working capital other than cash and cash equivalents	**$**	**2,513,860**

Attachment B

JOHNSON MEMORIAL HOSPITAL
CONSOLIDATED STATEMENT OF CASH FLOW

		September 30 2016
Operating activities and non-operating income		
Deficiency of revenues over expenses	**$**	**(3,473,942)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**2,839,922**
Bad debts		**2,385,036**
Decrease in pension and other accrued expenses		**(1,889,312)**
Other changes in net assets		**(160,459)**
Change in working capital, other than cash and cash equivalents		**5,287,169**
Net cash provided by operating activities		**4,988,414**
Investing activities		
Purchase of property, plant and equipment, net		**(2,002,371)**
Decrease in long term investments		**269,872**
Decrease in other assets		**(805,530)**
Net cash used in investing activities		**(2,538,029)**
Financing activities		
Principal payments on long-term debt		**(754,213)**
Net cash used in financing activities		**(754,213)**
Net increase in cash and cash equivalents		**1,696,172**
Cash and cash equivalents at beginning of period		**-**
Cash and cash equivalents at end of period	**$**	**1,696,172**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

		September 30 2016
Assets whose use is limited required for current liabilities	**$**	**208,225**
Accounts receivable--patients, net		**(11,271,174)**
Other current assets		**(3,309,083)**
Inventory of supplies		**63,398**
Prepaid expenses		**694,257**
		(13,614,377)
Changes in current liabilities:		
Accounts payable		**(4,954,229)**
Salary and wages, payroll taxes and amounts withheld from employees		**1,658,036**
Due to affiliates		**23,268,975**
Other current liabilities		**98,693**
Due to third party reimbursement agencies		**(1,169,929)**
		18,901,546
Changes in working capital other than cash and cash equivalents	**$**	**5,287,169**

Attachment C

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 16 YTD*	Sept 15 YTD	Comments
A. Operating Performance:			
Operating Margin	(6.8%)	(6.4%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	(0.4%)	(2.2%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	2.3%	1.8%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.4	current assets/current liabilites
Days Cash on Hand	9.6	8.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	100.8	53.3	net ar/net patient ser rev/days in yr
Average Payment Period	183.7	191.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	(399.0%)	410.1%	total debt/total equity(net assets)
Long-term Debt to Capitalization	135.5%	51.9%	LTD/LTD+net assets
Unrestricted Cash to Debt	7.6%	9.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	(4.0)	(3.3)	EBIT/Interest expense
Debt Service Coverage Ratio	(0.12)	(0.11)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	(11.3%)	8.1%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ (3,227)	$ (4,238)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ (3,474)	$ (4,009)	Net gain(loss)
EBIDA	$ (195)	$ (1,458)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,696	$ 1,676	from bs
Net Working Capital	$ (7,781)	$ (21,374)	current assets-current liabilities
Unrestricted Assets	$ (6,169)	$ (499)	from bs

*1/1/-9/30/16

Attachment C

Johnson Memorial Medical Center, Inc.

Monthly Financial Measurement/Indicators		Sept 16 YTD*		Sept 15 YTD	Comments
A. Operating Performance:					
Operating Margin		(7.4%)		(7.6%)	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		(1.2%)		(3.2%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		2.5%		1.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		0.8		0.30	current assets/current liabilites
Days Cash on Hand		10.8		6.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables		106.2		50.1	net ar/net patient ser rev/days in yr
Average Payment Period		175.0		227.0	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		3117.9%		(255.1%)	total debt/total equity(net assets)
Long-term Debt to Capitalization		96.8%		(51.0%)	LTD/LTD+net assets
Unrestricted Cash to Debt		9.2%		5.2%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		(4.8)		(3.5)	EBIT/Interest expense
Debt Service Coverage Ratio		(0.4)		(0.1)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		1.3%		-24.6%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations	$	(3,744)	$	(6,831)	Net income(loss) from operations
Revenue Over/(Under) Expense	$	(3,989)	$	(6,603)	Net gain(loss)
EBIDA	$	(617)	$	(2,909)	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	2,059	$	1,806	from bs
Net Working Capital	$	(5,887)	$	(41,006)	current assets-current liabilities
Unrestricted Assets	$	84	$	(18,536)	from bs

*1/1-9/30/16

Olejarz, Barbara

From: Cotto, Carmen
Sent: Monday, February 06, 2017 10:22 AM
To: Olejarz, Barbara
Cc: Roberts, Karen
Subject: FW: Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)

Hi Barbara,

Please add the email below in the paper/pdf file for the following docket number's record: TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045).

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Cotto, Carmen
Sent: Thursday, February 02, 2017 4:23 PM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org)
Cc: Roberts, Karen
Subject: Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)

Hi Claudio,

Below you will see some compliance follow up questions or issues for the Applicants to address.

Please note that this email is a follow up to your compliance submissions, for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045), on December 1, 2016 and that the separate issue related to the coordination of future filings due dates for the three Dockets will be discussed at a future time.

Please submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You can contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thanks,
Carmen

For Trinity Health-New England (TH-NE) (Docket#15-31979)

1. Condition#8 - Applicants provided the Hospital's Community Health Needs Assessment (CHNA) Implementation Strategy Plan. In reference to this plan, provide a narrative describing how the plan will address the community health needs listed on its CHNA.

2. Condition#14 - Applicants provided a written report that describes the culturally and linguistically appropriate services that are currently in place at the Hospital. In reference to this report, indicate how the Hospital utilized the standards published by the U.S. Department of Health and Human Services' Office of Minority Health as guidance for the development of the report.

For Johnson Memorial (Docket#15-32002)

3. Condition#8 - Provide Johnson Memorial's CHNA Implementation Strategy Plan and a narrative describing how the plan will address the community health needs listed on its CHNA. If not available, indicate when it will be available.

4. Condition#10 - Explain the zero amounts submitted as part of the Balance Sheet and Statement of Operations for the 1/1/16 to 9/30/16 period and resubmit the documents to include the missing data.

5. Condition#14 - Applicants did not provide a written report describing activities meeting culturally and linguistically appropriate services at the Johnson Memorial Hospital. Provide the missing report and indicate how the standards published by the U.S. Department of Health and Human Services' Office of Minority Health were used as guidance for the development of the report.

For Saint Mary's Hospital (Docket#15-32045)

6. Condition#4 - Elaborate on how Saint Mary's Hospital utilized the Healthy Connecticut State Health Improvement Plan data and priorities, as well as any applicable community health improvement plan issued by local health departments in the service area, as the starting point for the development of the Hospital's CHNA.

7. Condition#14 - Provide the status of the Community Representative selected to serve as a voting member of the Hospital's Board of Directors. Provide a narrative describing the selection process.

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Thursday, March 09, 2017 11:35 PM
To: User, OHCA; Cotto, Carmen
Cc: Janeanne C. Lubin-Szafranski; Schneider, Jennifer
Subject: TH-NE Responses to Conditions for CONs 15_32045 15_31979 15_32002
Attachments: Responses to Conditions 15_32045 15_31979 15_32002.pdf

Hello Carmen,

In response to your February 2, 2017 email titled, " Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)," attached are Trinity Health - New England's responses.

Please feel free to contact me with any questions you may have.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning and Business Development
Trinity Health - New England

claudio.capone@trinityhealth-ne.org
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Trinity Health
New England

Carmen Cotto
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue
MS#13HCA
P.O Box 340308
Hartford, CT 06134-0308

March 9, 2017

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England; Docket Number 15-31979-CON for Trinity Health – New England; Docket Number 15-32002-CON for Johnson Memorial

Dear Ms. Cotto:

In accordance with the TH-NE compliance follow up questions for the above CONs, enclosed is responses for each of the conditions noted.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

For Trinity Health-New England (TH-NE) (Docket#15-31979)

1. **Condition#8 - Applicants provided the Hospital's Community Health Needs Assessment (CHNA) Implementation Strategy Plan. In reference to this plan, provide a narrative describing how the plan will address the community health needs listed on its CHNA.**

   The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13, 2016. The 5 significant health needs identified in the Community Conversation Meeting included: Community Safety & Violence, Housing Insecurity, Family & Social Support, Employment & Poverty, Access to Care.

   In addition to findings from the Community Conversations, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services. And finally for the city of Hartford in particular the issues of unstable housing; violence; employment and education were all identified as significant needs.

   - **See Attachment 1** for the Implementation Strategy for Saint Francis Hospital and Medical Center
   - **See Attachment 2** for the Implementation Strategy for Mount Sinai Rehabilitation Hospital

2. **Condition#14 - Applicants provided a written report that describes the culturally and linguistically appropriate services that are currently in place at the Hospital. In reference to this report, indicate how the Hospital utilized the standards published by the U.S. Department of Health and Human Services' Office of Minority Health as guidance for the development of the report.**

   The Curtis D. Robinson Center for Health Equity was given the work of developing a comprehensive Language Services Program. In the last two years, phase I of the program has successfully been implemented around Saint Francis Medical Center, the Mount Sinai campus and our various off-site locations. The services include language

interpretation and translation of documents to assist patients who are deaf or hard of hearing, have a speech disability or have limited English skills. These resources are referred to as the 3 +1 Options and include telephone-based interpreting, video remote interpreting (VRI-MARTTI), in-person interpreting/ ASL or CDI and written translation of vital and non-vital documents. Each department on both campuses is equipped with dual handset phones for telephonic interpretation and there are 40 Video Remote Interpreter (VRI) - Martti carts on site on both campuses that are readily used by staff for patients and their companions. Off-site St. Francis Care physicians and non-St. Francis Care physician offices and affiliates who are on site also have access to language resources.

In addition to the already established Language Services Program, phase II of the program, the Qualified Medical Interpreter training, began shortly after. The training entails identifying qualified bi-lingual/multilingual staff to become Qualified Medical Interpreters. Thus far, there have been 4 cohorts to complete this training and a total of 30 staff members to successfully complete and pass the course. To partake in this training, each staff had to successfully pass the language proficiency assessment administered by Interpreters and Translators, Inc., (iTi), and complete the 40 hour in person training offered once a week for 5 weeks on-site at the Center for Health Equity. The training includes content such as the foundation of the profession of community interpreting, the code of ethics and standards of practice, culture and mediation and guides interpreters on how to intervene when a communication barrier arrives.

Most recently, based on OCR's Section 1557, all language service notices and signage were updated to include the top 15 Non-English Spoken languages indicating to all patients that language resources were available to them at no cost. As for the current state of the program, there are on-going in-person educational trainings for all medical staff, volunteers, learners and contractors. A newly revised annual health stream training for all current employees and new employees is available and there has been an update and enhancement of Martti software and distribution system. The medical interpreter training for qualified staff will continue as well bi-annually.

For Johnson Memorial (Docket#15-32002)

3. **Condition#8 - Provide Johnson Memorial's CHNA Implementation Strategy Plan and a narrative describing how the plan will address the community health needs listed on its CHNA. If not available, indicate when it will be available.**

The CHNA conducted in 2016 identified significant health needs within the JMH community. Those needs were then prioritized based on a Community Conversation and focus groups with key stakeholders held during 2016. Significant health needs identified, in order of priority include: Healthy Behavior Change Diet & Exercise, Substance Abuse & Tobacco Use, Access to health care, and Poverty & Employment.

- **See Attachment 3** for the Implementation Strategy for Johnson Memorial

4. **<u>Condition#10</u> - Explain the zero amounts submitted as part of the Balance Sheet and Statement of Operations for the 1/1/16 to 9/30/16 period and resubmit the documents to include the missing data.**

   Please reference the response for the above condition in the email submission from Mary Lou Rosadini on February 13, 2017.

5. **<u>Condition#14</u> - Applicants did not provide a written report describing activities meeting culturally and linguistically appropriate services at the Johnson Memorial Hospital. Provide the missing report and indicate how the standards published by the U.S. Department of Health and Human Services' Office of Minority Health were used as guidance for the development of the report.**

   Johnson Memorial Hospital has adopted the work done at Saint Francis Hospital and Medical Center as it relates to linguistically appropriate services. The Curtis D. Robinson Center for Health Equity was given the work of developing a comprehensive Language Services Program. In the last two years, Phase I of the program has successfully been implemented at Johnson Memorial Hospital and its off-site locations. The services include language interpretation and translation of documents to assist patients who are deaf or hard of hearing, have a speech disability or have limited English skills. These resources are referred to as the 3 +1 Options and include telephone-based interpreting, video remote interpreting (VRI-MARTTI), in-person interpreting/ ASL or CDI and written translation of vital and non-vital documents. Each department on both campuses is equipped with dual handset phones for telephonic interpretation and there are 40 Video Remote Interpreter (VRI) - Martti carts on site on both campuses that are readily used by staff for patients and their companions. Off-site Johnson Memorial Hospital physicians and non- Johnson Memorial Hospital physician offices and affiliates who are on site also have access to language resources.

   Most recently, based on OCR's Section 1557, all language service notices and signage were updated to include the top 15 Non-English Spoken languages indicating to all

patients that language resources were available to them at no cost. As for the current state of the program, there are on-going in-person educational trainings for all medical staff, volunteers, learners and contractors. A newly revised annual health stream training for all current employees and new employees is available and there has been an update and enhancement of Martti software and distribution system. The medical interpreter training for qualified staff will continue as well bi-annually. There is an annual review of language access needs of the patient population served by Johnson Memorial Hospital.

For Saint Mary's Hospital (Docket#15-32045)

6. **Condition#4 - Elaborate on how Saint Mary's Hospital utilized the Healthy Connecticut State Health Improvement Plan data and priorities, as well as any applicable community health improvement plan issued by local health departments in the service area, as the starting point for the development of the Hospital's CHNA.**

   In collaboration with the Greater Waterbury Health Improvement Partnership (GWHIP), Saint Mary's Hospital along with five additional organizations, including the City of Waterbury Health Department utilized the Healthy Connecticut State Health Improvement Plan (2014). The data and priorities within the Healthy Connecticut State Health Improvement Plan were observed and the roadmap to complete the stated initiatives were noted throughout the community-wide coalition. In addition, the Greater Waterbury Health Improvement Partnership used the data to ensure that the service areas that are included within the 2016 Community Health Needs Assessment will benefit and see successful results in advancing Connecticut's population health. With the seven focus areas that were touched on in the Healthy Connecticut State Health Improvement Plan, the Greater Waterbury Health Improvement Partnership plans to address the following five which all fall into the addressed priorities of the state including: Access to Care, Mental Health/Substance Abuse, Chronic Disease, Tobacco Use and Asthma, and Health Communications. It should be noted that Saint Mary's Hospital 2016 Community Health Needs Assessment Implementation Plan was filed publicly on Wednesday, February 15, 2017 and shows the direct alignment with the Healthy Connecticut State Health Improvement Plan.

   - **See Attachment 4** for the Saint Mary's Hospital 2016 Community Health Needs Assessment Implementation Plan

7. **<u>Condition#14</u> - Provide the status of the Community Representative selected to serve as a voting member of the Hospital's Board of Directors. Provide a narrative describing the selection process.**

   As required in the Agreed Settlement, the Saint Mary's Hospital Board Chair, and the President, consulted Waterbury Mayor Neil O'Leary in August 2016 regarding the appointment of a community representative to serve as a voting member of the Saint Mary's Hospital Board. The Mayor recommended Attorney Linda Wihbey, Corporation Counsel for the City of Waterbury, as a person who will effectively and without bias, consider matters affecting quality and safety, and the health needs of the local community. Attorney Whibey's appointment was approved by the Saint Mary's and the Trinity Health-New England boards in September 2016.

ATTACHMENT 1

Saint Francis Hospital and Medical Center
Community Health Needs Assessment Implementation Strategy
2016 - 2019

Saint Francis Hospital and Medical Center (SFHMC) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on June 22, 2016. SFHMC performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community members, and various community organizations.

The complete CHNA report is available electronically at http://www.saintfranciscare.com/About_Us/Hospital_Publications.aspx or printed copies are available by emailing: plarivie@stfranciscare.org

Hospital Information and Mission Statement

MISSION
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CORE VALUES

- **Reverence:**
  We honor the sacredness and dignity of every person.
- **Commitment to Those who are Poor:**
  We stand with and serve those who are poor, especially those most vulnerable.
- **Justice:**
  We foster right relationships to promote the common well, including sustainability of Earth.
- **Stewardship:**
  We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- **Integrity:**
  We are faithful to who we say we are.

Saint Francis Hospital and Medical Center's service area comprises urban, suburban, and rural communities that together form a rich mixture of highly diverse races and ethnicities, and a wide range of socioeconomic categories.

Its primary service area includes 25 towns and corresponds largely with the greater Hartford region. The Hospital's secondary service area includes 28 towns largely to the west and south of the primary service area. These towns are more rural, and their needs are very different than those of the city of Hartford, which has more than three times as many patients discharged from Saint Francis than any other municipality.

A comparison of population density, household income, and median age reveal that these communities are anything but uniform, and the resources for addressing concerns and needs of their residents differ as well. Yet, many of the health issues they face are similar; obesity, diabetes, heart disease, and behavioral health were all mentioned by the leaders of health districts who serve these towns.

Hartford's population of 125,000 is composed of all races and myriad ethnicities. Some 44 percent of its citizens are Hispanic/Latino and 35 percent Black/African American, with subgroups that include refugees and immigrants

from Africa, Eastern Europe, the Middle East, Asia, South America, and the West Indies. Additionally, 22 percent of the total population in Hartford is foreign born, bringing a tremendous diversity to the city.

The city is proportionately younger than the rest of the state as well as the country; over 25 percent of its residents are under age 17 and only 9 percent are over age 65, compared to 22 percent and 15 percent respectively for the state as a whole. This affects age-related health issues, such as some forms of cancer, violence, and accidental injury.

Hartford is a city of vibrant neighborhoods – 17 distinct neighborhoods, to be exact – with a variety of housing stock ranging from high-rise downtown luxury apartments and condos to historic houses to single-family homes and a variety of rental options. The city's many neighborhoods are supported by a roster of community organizations that focus on issues, such as economic development, housing, and assimilation of new immigrants, education, and historic preservation.

Health Needs of the Community

The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13th. The 5 significant health needs identified in the Community Conversation Meeting included:

Community Safety & Violence	• Ranked as the highest priority at the Community Conversation Meeting • 54% of Hartford residents said it was not safe to walk in their neighborhood
Housing Insecurity	• Home ownership is only 26% in Hartford • 32% of renters are subsidized
Family & Social Support	• 59% of residents said they "do not trust neighbors" • Limited support for positive health behaviors
Employment & Poverty	• Only 59% of Hartford residents are regularly employed • 79% of Hartford household are below adequate income levels
Access to Care	• 50% of residents are worried about the cost of care • 23% of residents don't have a regular doctor

In addition to findings from the Community Conversation, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services. And finally for the city of Hartford in particular the issues of unstable housing; violence; employment and education were all identified as significant needs.

Hospital Implementation Strategy

Saint Francis Hospital and Medical Center's resources, mission, goals, strategic priorities and the significant health needs identified through the most recent CHNA process were all considered during the development of the hospital's Implementation Strategy. The Hospital's Well Being 360 (WB360) project, which was selected to be part of Trinity Health's national Transforming Communities Initiative, combines resources from the hospital, community groups, state and local government departments, and national resources to create a collaborative approach to improving the health of the community.

The WB360 project will address identified health needs by:

- Engaging in an **anchor institution** approach designed to impact high-need neighborhoods in Hartford's North End by addressing social determinants of health.

- Encouraging health behavior change through the support of evidence-based programs in the areas of **diet, exercise** and support for changes in **tobacco policy.**

- Testing a model of clinical care that integrates the healthcare delivery system with social support programs, with a specific focus on **behavioral health.**

- Transforming the physical environment through support of local partner agencies working to improve **housing, neighborhood safety** and opportunities for **physical activity.**

Transforming Communities - Well Being 360
The Implementation Strategy to be executed by SFHMC is called the Well Being 360 and includes an investment from the hospital as well as leveraged resources from the Trinity Health system and community partnering agencies. The work will include the development of a coalition with the goal of bringing all of the varied resources to the table for collective impact approaches to address the social determinants of health that are so significant in the city's poorest neighborhoods. The work will involve community investments based on a set of principles agreed upon by the WB360 Steering Committee. Well Being 360 investments will be made based on:

1. Alignment with CHNA identified needs and health system priorities;
2. Strong evidence of effectiveness in achieving targeted outcomes;
3. Capacity to implement solutions and build coalition with community partners and residents;
4. Value of the investment (impact per dollar invested) in achieving short-term and longer-term outcomes; and
5. Sustainability of solution after initial investment.

Significant Health Needs That Will Not be Addressed:
SFHMC acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. SFHMC will not take action on the following health needs:

- Housing Insecurity
  The Partnership for Stronger Communities has done significant work in the area of homelessness prevention and is taking the lead on this community health issue. We will collaborate with them on this work but expect to serve in a supportive role.

- Employment and Poverty:
  The health collaborative being developed by our partner Community Solutions in the North End of Hartford will serve as the leader for this work.

- Sexual Activity:
  The City of Hartford has a strong program in this area and this issue was rated as a low priority in our Community Conversation.

- Air and Water Quality:
  Although these were mentioned by community members as a concern, the City of Harford and its partner agencies are focused on this work.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending in September of 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Community Safety and Violence		
CHNA REFERENCE PAGE:	P. 23	**PRIORITIZATION #:** 1	
BRIEF DESCRIPTION OF NEED: Excessive violence, concerns for safety in neighborhoods, and lack of opportunities for diversion.			
GOAL: Create partnerships with four local organizations to increase diversionary options for youth and improve the physical environment to promote safety.			
OBJECTIVE: Work with local community agencies and develop a work group on violence prevention.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Develop a coalition work group focused on violence prevention. 2. Provide monetary support to community agencies. 3. Identify best practices for small cities.			
ANTICIPATED IMPACT OF THESE ACTIONS: 1. Stronger collaborative relationships. 2. Strengthened community agencies focused on violence prevention. 3. By next survey, increased feelings of safety.			
PLAN TO EVALUATE THE IMPACT: DataHaven Survey – Comparison of 2019 and 2016. Community Conversations			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coalition Leadership Monetary Support of Partners.			
COLLABORATIVE PARTNERS: Hartford Communities That Care Community Solutions Peace Builders			

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Family and Social Support (Healthy Behaviors - Diet & Exercise)		
CHNA REFERENCE PAGE:	20	**PRIORITIZATION #:** 2a	

BRIEF DESCRIPTION OF NEED:

High rates of Obesity, Diabetes and Heart Disease are impacted significantly by behaviors. In Hartford, the Obesity rate is 33% and those impacted by diabetes in a survey completed by the CDRCHE included 68% of participants.

GOAL:
Provide easily accessible programs that focus on healthy eating and active living behaviors that result in positive health changes.

OBJECTIVE:
Engage 120 participants in the first year of the programs and establish and on-going, sustainable process for providing the programs to those residents with the highest need.

Collaborate with the Complete Streets Committee to move forward on changes to the environment that encourage physical activity.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify appropriate partners to provide the programs in community settings.
Develop a referral system to identify high need patients and provide high quality actionable referrals.
Invest in programs to they can be provide free of charge to patients and residents in need of these support services.

ANTICIPATED IMPACT OF THESE ACTIONS:
Better relationships with program participants.
Increase knowledge and healthy behaviors for those who complete the programs.
Improved long term health outcomes.

PLAN TO EVALUATE THE IMPACT:
Pre and post-test screening of knowledge and behavior.
Development of Patient Advisory Board to support on-going engagement.
In year 3 - Review of health records for up to 10% of program participants.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
Well Being 360 Investment
In-Kind support for data collection and program evaluation.

COLLABORATIVE PARTNERS:
YMCA - Diabetes Prevention Program
Live Well – Diabetes Prevention Program
Cooking Matters – Food Access and Budgeting Program
City of Hartford Complete Streets Committee

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Family and Social Support (Resources for Tobacco Use)		
CHNA REFERENCE PAGE:	21	**PRIORITIZATION** #: 2b	
BRIEF DESCRIPTION OF NEED: Tobacco Use in Connecticut is at 16%, well above the Healthy People 2020 goal of 12%. Rates among Connecticut youth are similar to adults, which highlight an opportunity to have an impact on health outcomes.			
GOAL: Make changes to tobacco policy at the state and local level to support tobacco cessation. Focus on youth smoking rates			
OBJECTIVE: Collaborate with a statewide coalition to encourage tobacco use cessation. Develop relationships with clinical leaders to improve tobacco screening and referral.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Identify local resources for patients and others to access. Engage youth and others in messaging about tobacco cessation.			
ANTICIPATED IMPACT OF THESE ACTIONS: Change in legislation that makes it harder to market e-cigarettes. Improved messaging on campus about the prohibition of tobacco products of all kinds including e-cigarettes. Decreased uptake of smoking among young adults.			
PLAN TO EVALUATE THE IMPACT: Review legislative accomplishments for the past 12 months. Identify signage changes regarding tobacco free campus. Examine rates of smoking in young adults.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Well Being 360 Investment Changes in campus wide signage			
COLLABORATIVE PARTNERS: MATCH Coalition Regional Health Ministry Sites: Johnson Memorial; Mount Sinai; Saint Mary's; Mercy Medical Center			

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare (Focus on Behavioral Health)		
CHNA REFERENCE PAGE:	23	**PRIORITIZATION #:** 3	
BRIEF DESCRIPTION OF NEED: Access to behavioral health services is limited for patients on Medicaid and over 40 of survey respondents said they feel down sometimes or often. According to the report, My Brothers Keeper 06120, trauma and behavioral health impact academic performance; criminal behavior; ability to develop trusting relationships; employment and drug use.			
GOAL: Develop and pilot an electronic referral system embedded in the EMR that enables providers to make referrals and monitor follow through.			
OBJECTIVE: Enroll 300 patients in the program and monitor the delivery of support services to those referred.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Partner with community agency to develop the project. Collaborate with home care agencies who provide in home clinical and social support services. Monitor outcomes of the project to determine feasibility of large scale implementation.			
ANTICIPATED IMPACT OF THESE ACTIONS: Improved satisfaction for patients enrolled in the project. Decreased need for urgent care services. Increased stability in patient's lives.			
PLAN TO EVALUATE THE IMPACT: Survey of patient satisfaction. Monitor use of ED services. Interview sample of patients about quality of life changes.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coordination of project activities in safety net clinics. Collaboration with partner agencies in meetings; problem solving and monitoring of program outcomes. Support for grant funding applications.			
COLLABORATIVE PARTNERS: Community Solutions Ambulatory Care Clinic Home Care Agency (yet to be identified) Intercommunity; Wheeler Clinic			

Adoption of Implementation Strategy

On 1-20-17 the Mission Committee of the Board of Directors for Saint Francis Hospital & Medical Center met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment. Upon review, the Mission Committee recommends approval by the full Board of Directors at their next meeting of this Implementation Strategy and the related budget.

Name & Title SVP Mission Integration Trinity Health - New England

01/25/2017
Date

ATTACHMENT 2

Mount Sinai Rehabilitation Hospital
Community Health Needs Assessment Implementation Strategy
2016 - 2019

Mount Sinai Hospital (MSRH) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on September 30, 2016. SFHMC performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community members, and various community organizations.

The complete CHNA report is available electronically at http://www.saintfranciscare.com/About_Us/Hospital_Publications.aspx or printed copies are available by emailing: plarivie@stfranciscare.org

Hospital Information and Mission Statement

MISSION
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CORE VALUES

- **Reverence**:
  We honor the sacredness and dignity of every person.

- **Commitment to Those who are Poor:**
  We stand with and serve those who are poor, especially those most vulnerable.

- **Justice:**
  We foster right relationships to promote the common well, including sustainability of Earth.

- **Stewardship:**
  We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

- **Integrity:**
  We are faithful to who we say we are.

Mount Sinai Rehabilitation Hospital's service area comprises urban, suburban, and rural communities that together form a rich mixture of highly diverse races and ethnicities, and a wide range of socioeconomic categories. Most patients seen have disabilities; spinal cord injuries; brain injuries; and complications due to stroke. Stroke is the most common reason for hospitalization and risk factors include diabetes, obesity and smoking; all of which were identified in the CHNA as priorities. Additionally, patients with Multiple Sclerosis and other neurological diseases are frequently served by Mount Sinai Rehabilitation Hospital. Trauma due to gunshots, violence, motor vehicle accidents and other accidents are also common; as are amputees who suffer with diabetes. Mount Sinai serves to treat the consequences of these conditions with primary treatment and engages in secondary prevention through education, community outreach and programs to reduce incidence.

Mount Sinai serves the entire State of Connecticut. Its primary service area includes 25 towns and corresponds largely with the greater Hartford region. The Hospital's secondary service area includes 28 towns largely to the west and south of the primary service area.

Hartford's population of 125,000 is composed of all races and myriad ethnicities. Some 44 percent of its citizens are Hispanic/Latino and 35 percent Black/African American, with subgroups that include refugees and immigrants from Africa, Eastern Europe, the Middle East, Asia, South America, and the West Indies. Additionally, 22 percent of the total population in Hartford is foreign born, bringing a tremendous diversity to the city. The city is proportionately younger than the rest of the state as well as the country; over 25 percent of its residents are under age 17 and only 9 percent are over age 65, compared to 22 percent and 15 percent respectively for the state as a whole. This affects age-related health issues, such as some forms of cancer, violence, and accidental injury. The MSRH has a special focus on veterans and on neurological illnesses especially multiple sclerosis

Health Needs of the Community

The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13th. The 5 significant health needs identified in the Community Conversation Meeting included:

Community Safety & Violence	• Ranked as the highest priority at the Community Conversation Meeting • 54% of Hartford residents said it was not safe to walk in their neighborhood
Housing Insecurity	• Home ownership is only 26% in Hartford • 32% of renters are subsidized
Family & Social Support	• 59% of residents said they "do not trust neighbors" • Limited support for positive health behaviors
Employment & Poverty	• Only 59% of Hartford residents are regularly employed • 79% of Hartford household are below adequate income levels
Access to Care	• 50% of residents are worried about the cost of care • 23% of residents don't have a regular doctor

In addition to findings from the Community Conversation, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services.

Hospital Implementation Strategy

Mount Sinai Rehabilitation Hospital's resources, mission, goals, strategic priorities and the significant health needs identified through the most recent CHNA process were all considered during the development of the hospital's Implementation Strategy.

The health priorities for the Mount Sinai Rehabilitation Hospital and the Mandell Center for Comprehensive Multiple Sclerosis Care include:

1. Access to comprehensive rehabilitation facilities (focus on Veterans)
2. Patient frustration with disjointed rehabilitation care
3. Lack of coordinated and comprehensive care for MS patients
4. Increased need for research to better understand MS treatment options

The Physical Medicine and Rehabilitation (PM&R) Service Line at Mount Sinai Rehabilitation Hospital strives to facilitate and enhance individual recovery, function, and optimal performance with an emphasis on those populations with impairments that either place them at risk or result in temporary and/or permanent disability.

It serves as a regional and national leader in the delivery of coordinated rehabilitation services providing;

2015

- Neurology
  - Neurologist 4 days/wk
  - PA Full time
  - Recruiting second neurologist
- Physiatry
- Urology
  - Urologist 1.5 days/wk
  - Urodynamics RN
  - Ultrasound tech
- Infusion Center
  - Infusion Nurse Full time
  - Per diem Infusion Nurses-2
  - Medical Assistant
- Case Management
- Skilled Therapy:
  - PT (3), OT (2), ST (1) –dedicated MS team
- Neuropsychology
- New Services
  - Pharmacy
  - Integrative Medicine(yoga, accupuncture)

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Rehabilitation Healthcare Services (focus on veterans)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 1	

BRIEF DESCRIPTION OF NEED:
Veterans are in need of support programs focusing on their unique set of needs.

GOAL:
Improve the resources, and increase the quality of the programs available for Veterans

OBJECTIVE:
Enhance the relationship with the Veterans Administration to provide high quality accessible rehabilitation services across the state to veterans in need of support.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Increase staff appropriately
- Establish referral coordinator program to facilitate proper patient transitions to MSRH
- Create educational/training programs

ANTICIPATED IMPACT OF THESE ACTIONS:
- Improve access of programs for Veterans
- Broaden array of resources
- Increase participation of Veterans in support programs

PLAN TO EVALUATE THE IMPACT:
- Patient Satisfaction Survey Responses
- Conversations with Veterans Administration Leadership
- Number of veterans participating in programs

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- Staffing for Outreach to the Veteran population
- Leadership participation at board level or committees with a focus on Healthcare for Veterans
- Amputee Informational series
- Health & Fitness Initiatives through Outpatient Services
- Community Outreach Programs including: Adaptive Rowing; Golfers in Motion; and others.

COLLABORATIVE PARTNERS:
1. Quinnipiac University
2. Department of Veterans Affairs

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Rehabilitative Services (continuity of rehabilitation services)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 2	

BRIEF DESCRIPTION OF NEED:
Provide comprehensive rehabilitation services to those who suffer from brain injury, stroke, heart disease and other chronic illness.

GOAL:
Enhance efficiency in recovery, community reintegration and secondary prevention.

OBJECTIVE:
Improve long-term functional and health status and improve the likelihood of independent living and a high quality of life

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Education and Training for rehabilitation professionals, patients, and the community
- Research and clinical innovation to advance in the field of rehabilitation medicine
- Advocacy in partnerships to ensure the needs of those with disabilities are recognized, understood, and addressed by policy makers

ANTICIPATED IMPACT OF THESE ACTIONS:
- Reduce the likelihood of complications, relapse, and/or re-hospitalizations
- Halt or slow the progression of primary and secondary disabilities (maintain functioning and prevent further deterioration)

PLAN TO EVALUATE THE IMPACT:
- Monitor discharge, transfers and readmissions rates
- Report on capability to manage patient population
- Outline set of added services

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- Powerful Tools For Caregivers
- Integrative Medicine- Acupuncture, massage on campus
- Monthly Stroke Survivors Support Group
- Spinal Cord injury Informational Series
- Community Outreach Programs including: Adaptive Rowing; Golfers in Motion and others

COLLABORATIVE PARTNERS:
- Acute Care Hospitals and Trauma Centers across the state
- Emergency Department staff
- CT State Department of Public Health
- Stoke Center at SFHMC

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare (rehabilitation services for patients with MS)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 3 & 4	

BRIEF DESCRIPTION OF NEED:
Provide comprehensive interdisciplinary care for those with Multiple Sclerosis to achieve optimal outcomes.

GOAL:
Become Center of Excellence for MS. Provide high quality state of the art care to those suffering from Multiple Sclerosis. Expand community access for our Center of Excellence for MS.

OBJECTIVE:
- Expand services area reach beyond current primary service area.
- Increase partners in order to address disjointed care
- Advocate at the payor and legislative level regarding access to services

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Enhance the coordination of MS Care
- Improve research portfolio and numbers of patients involved in trials
- Integrate State of the art technologies to enhance clinical outcomes

ANTICIPATED IMPACT OF THESE ACTIONS:
- Value driven rehabilitation care across the continuum
- Work with partners to ensure the needs of those with MS are addressed by policymakers

PLAN TO EVALUATE THE IMPACT:
- Measure the development of innovative interdisciplinary care programs
- Increase in portfolio of new technology, trials and robotics (hyperbaric chamber treatment)
- Improved research infrastructure

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- C.A.R.P. Community Adaptive Rowing Program
- Golfers in Motion and other Physical Therapy Programs
- Men's MS Support Group
- Patient Led Support Group for individuals with MS
- MS International Symposium Patient Day (Education, Resources, support for individuals with MS, families & clinicians)
- MS center facilitated Education Seminars for Patients with MS/families related to DMT options

COLLABORATIVE PARTNERS:
1. Multiple Sclerosis Society
2. Research Support
3 Mandell Family Foundation

Adoption of Implementation Strategy

On 1-24-17 the Mission Committee of the Board of Directors for Mount Sinai Rehabilitation Hospital met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment Upon review, the Mission Committee recommends approval by the full Board of Directors at their next meeting of this this Implementation Strategy and the related budget

Howard Orr 1/25/17

Howard Orr
Mount Sinai Rehabilitation Hospital
Board Chairman

Date

ATTACHMENT 3

Trinity Health – New England
Johnson Memorial Hospital
Community Health Needs Assessment Implementation Strategy
Fiscal years 2016-2019

Johnson Memorial Hospital (JMH) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on 2-7-17. JMH performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at www.jmmc.com or printed copies are available from Patricia Lariviere plarivie@stfranciscare.org

Hospital Information and Mission Statement

Mission

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values

Reverence
We honor the sacredness and dignity of every person.

Commitment to those who are poor
We stand with and serve those who are poor, especially those most vulnerable.

Justice
We foster right relationships to promote the common good, including sustainability of Earth.

Stewardship
We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity
We are faithful to who we say we are.

Johnson Memorial Hospital is a 92-bed hospital located in Stafford Springs Connecticut that has been an anchor institution in north central Connecticut for 104 years. The Hospital moved from its original location on East Street in Stafford Springs to its present location on Chestnut Hill Road in 1975. During the 1980s, few health care organizations throughout the United States were branching out by creating subsidiaries, and Johnson Memorial Hospital (JMH) was one of the first to bring this type of business structure to Connecticut. Early in the decade, Johnson Health Care, Johnson Development Fund and Wellcare joined Johnson Memorial Hospital under the Johnson Memorial Corporation umbrella. Soon after, the

organization opened Connecticut's first free-standing, hospital-affiliated outpatient surgery center, Johnson Surgery Center. In the intervening years, Johnson has continued expanding services to meet the community's needs. In September 2010, JMH emerged from Chapter 11 as an independent, community-based health care provider as it had been for nearly a century. In July of 2012, JMH and Saint Francis *Care* signed an Affiliation Agreement, resulting in a mutually beneficial relationship that has provided the community with a sustainable, high quality healthcare resource. As a result, JMH has experienced improved operations by all measures of financial performance.

In 2016, Johnson Memorial Hospital and the other Johnson entities became part of Trinity Health - New England, an integrated health care delivery system that is a member of Trinity Health, Livonia, MI, one of the largest multi-institutional Catholic health care delivery systems in the nation. Today, Johnson Memorial Hospital and Home & Community Health Services provide a continuum of health care services to those living and working in north central Connecticut and western Massachusetts.

Health Needs of the Community

The CHNA conducted in 2016 identified significant health needs within the JMH community. Those needs were then prioritized based on a Community Conversation and focus groups with key stakeholders held during 2016. Significant health needs identified, in order of priority include:

Healthy Behavior Change: Diet & Exercise	• 66% of JMH survey respondents are either overweight or obese • High Blood Pressure is the leading cause of hospitalization.
Substance Abuse & Tobacco Use	• Opioid use had increased significantly • 16% of CT adult smoke and youth rates are similar
Access to health care.	• 23% of residents indicate postponing care due to access. • Of those 56% said that cost was a significant factor.
Poverty and Employment	• Although the population is educated, employment opportunities are limited. • 12% of residents indicated the need to participate in food pantries due to limited income for food.

Hospital Implementation Strategy

JMH resources and overall alignment with the hospital's mission, goals and strategic priorities were taken into consideration of the significant health needs identified through the most recent CHNA process.

Significant health needs that will not be addressed

Johnson Memorial Hospital acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only

those health needs which it deemed most pressing, under-addressed, and within its ability to influence. JMH will not take action on the following community needs:

- **Poverty and lack of employment opportunities.**
- **Lack of public transportation resources.**

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Support for Healthy Behavior Change: Diet & Exercise		
CHNA REFERENCE PAGE:	Pages 15,17,18	**PRIORITIZATION #:** 2	

BRIEF DESCRIPTION OF NEED:

High rates of Obesity, Diabetes and Heart Disease are impacted significantly by behaviors. In the JMH service area 66% of residents are either overweight or obese. And high blood pressure is the most common reason for hospitalization.

GOAL:
Provide easily accessible programs that focus on healthy eating and active living behaviors that result in positive health changes.

OBJECTIVE:
Engage 60 participants in the first year of the programs and establish and on-going, sustainable process for providing the programs to those residents with the highest need.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify appropriate partners to provide the programs in community settings.
Develop a referral system to identify high need patients and provide high quality actionable referrals.
Invest in programs so they can be provide free of charge to patients and residents in need of these support services.

ANTICIPATED IMPACT OF THESE ACTIONS:
Better relationships with program participants.
Increase knowledge and healthy behaviors for those who complete the programs.
Improved long term health outcomes.

PLAN TO EVALUATE THE IMPACT:
Pre and post-test screening of knowledge and behavior for program participants.
In year 3 - Review of health records for up to 10% of program participants.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
In-Kind support for data collection and program evaluation.

COLLABORATIVE PARTNERS:
American Heart Association
Diabetes Prevention Programs

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Substance Abuse and Tobacco Use		
CHNA REFERENCE PAGE:	17	**PRIORITIZATION** #: 3	

BRIEF DESCRIPTION OF NEED:
Tobacco Use in Connecticut is at 16%, well above the Healthy People 2020 goal of 12%. Rates among Connecticut youth are similar to adults, which highlight an opportunity to have an impact on health outcomes.
Opioid use has increased significantly in the rural areas of the service area.

GOAL:
Make changes to tobacco policy at the state and local level to support tobacco cessation.
Engage programs that focus on youth smoking rates
Develop a set of substance abuse prevention and treatment resources.

OBJECTIVE:
Collaborate with a statewide coalition to encourage tobacco use cessation.
Develop relationships with clinical leaders to improve tobacco screening and referral.
Engage partners in development of resources for opioid abuse.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify local resources for patients and others to access.
Engage youth and others in messaging about tobacco cessation.

ANTICIPATED IMPACT OF THESE ACTIONS:
Change in legislation that makes it harder to market e-cigarettes.
Improved messaging on campus about the prohibition of tobacco products of all kinds including e-cigarettes.
Decreased uptake of smoking among young adults.
Identification and education of providers and others about resources to address substance abuse.

PLAN TO EVALUATE THE IMPACT:
Review legislative accomplishments for the past 12 months.
Identify signage changes regarding tobacco free campus.
Examine rates of smoking in young adults with Data Haven support.
Survey of providers and patients about knowledge of substance abuse resources.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
Changes in campus wide signage
In-Kind support for resource identification

COLLABORATIVE PARTNERS:
MATCH Coalition
Regional Health Ministry Sites: Johnson Memorial; Mount Sinai; Saint Mary's; Mercy Medical Center

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare		
CHNA REFERENCE PAGE:	20	**PRIORITIZATION #: 1**	
BRIEF DESCRIPTION OF NEED: 23% of survey participants indicated they have postponed healthcare in the past 12 months because of limited access. The most common reason sited was cost with 56% of those who said the postponed care attributing cost to the reason for doing so.			
GOAL: Work to improve understanding of healthcare costs; improve enrollment in health insurance and decrease the numbers reporting that care is postponed due to access.			
OBJECTIVE: Enroll 100 patients in health insurance or programs or screen them for financial assistance for healthcare resources. Educate providers and patients about the resources available for those with limited income.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Partner with community agency to develop an outreach effort about health insurance resources and the importance of financial screening.			
ANTICIPATED IMPACT OF THESE ACTIONS: Improved satisfaction for patients and greater access to needed health resources. Increased stability in patient's lives.			
PLAN TO EVALUATE THE IMPACT: Survey of patient satisfaction. Measure of patient health insurance coverage.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coordination of financial screening resources from Saint Francis with Johnson staff. Staffing of educational programs about health resources in the community.			
COLLABORATIVE PARTNERS: **Saint Francis Hospital** **Financial Aid Counselors** **ACCESS Health CT**			

Adoption of Implementation Strategy

On 2-7-17 the Board of Directors for Johnson Memorial Hospital met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment. The Board adopted the plan and related budget and designated the chairman of the board to sign the documents for approval.

Patrick Mahon, Chairman

2/15/17
Date

ATTACHMENT 4

Saint Mary's Hospital
Community Health Needs Assessment

Implementation Plan 2016

Saint Mary's HOSPITAL

Exceptional care. Every patient. Every day.

2016 Community Health Needs Assessment Implementation Plan

Following the 2016 Community Health Needs Assessment, Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors at Saint Mary's Hospital. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the five priority areas are listed below.

I. Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

Key Indicators

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

Existing Programs

Hospital-Based Access to Care Programs

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2016, these advocates assisted 1,558 individuals in obtaining insurance coverage.
- In January 2014, Saint Mary's began the insurance and cost estimate program was implemented. Patients, who request an estimate, now receive a document that estimates the cost of care.
- Saint Mary's has a patient tracking system for its Same Day Surgery department as of September 2013.
- Saint Mary's has a comprehensive communication strategy to promote primary care and urgent care through direct patient education, community health events and marketing communications such as search engine optimization, online appointment booking and digital media strategies.
- Saint Mary's promotes the use of a patient's electronic health record as a means of providing access to patient's health information including medications, providers and office visits.
- In October 2016, Saint Mary's installed signage in multiple languages that educates patients and visitors to use our language and interpretation services.
- Saint Mary's is a partner in the Waterbury Health Access Program which improves access to high-quality medical care for uninsured and underinsured residents of Greater Waterbury.
- Saint Mary's Family Health Center and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have Medicaid. Thousands of patients receive services through these clinics.

Grant-Funded

- Saint Mary's has grant funding from the Connecticut Department of Public Health for The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP), which was formerly known as the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS). This program provides screening for breast, cervical and colorectal cancer and if a cancer is diagnosed through the grant, funds are available for treatment.
- As one of five hospitals in the state of Connecticut, Saint Mary's received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs (CYSHCN). This program develops care plans and provides healthcare regardless of income for children and youth with chronic physical and/or behavioral issues not only to Saint Mary's practices but to the community as well.

Initiatives

- Explore further options of care using the PUMP Club model (see section III., Healthy Lifestyles) of direct-to-care access.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care, Waterbury Health Access Program) for uninsured/underinsured and low income patients and families.
- Explore further development of nurse navigator programs to improve access to primary care and behavioral health.
- Evaluate need for additional mobile screening vehicles in the Greater Waterbury market
- Continue to enhance Autism-friendly space and training for emergency department providers

II. Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase mental health and substance abuse screening by primary care providers
- Increase number of points of access for referral to services

Key Indicators

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental or behavioral health.
- Length of stay in ED for mental or behavioral health patients.
- Number of ED referrals for mental or behavioral health care services.
- Number of patients who utilize outpatient behavioral health services.

Existing Programs

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 15, 637 patients were discharged from the unit. The average length of stay in the unit is 6.5 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,700 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2015, 13,254 ED patients had a primary or secondary diagnosis related to behavioral health. These patients represent 18% of total visits (71,762). The average length of stay for behavioral health patients in 2015 the ED was 33 hours or 1.4 days.
- In 2016, Saint Mary's implemented Enhanced Recovery After Surgery (ERAS), a program designed to reduce or eliminate the use of narcotics in surgery.

Initiatives

- Spearhead efforts to create and organize a Community Care Team focused on high risk behavioral health patients with efforts from the Greater Waterbury Health Improvement Partnership.
- Complete construction of Behavioral Health unit in the Emergency Department to better meet patient needs.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions, Association of Ambulatory Behavioral Health, and the Mental Health Association of Connecticut.
- Increase education and percentage of narcotic-free surgeries completed at Saint Mary's Hospital.
- Continue to evaluate use of telemedicine for mental and behavioral health.

III. Healthy Lifestyles (Obesity, Heart Disease, and Diabetes)

Goal: Reduce chronic health disease through awareness and education.

Objectives:

- Enact process to collect data within Physician Network Organization on patient Body Mass Index (BMI) levels.

Key Indicators

- Number of patients with a Body Mass Index (BMI) screening.
- Number of patients with a calculated Body Mass Index (BMI) of overweight or obese that were referred to additional care.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children who receive meals through the Health Nutrition Grant.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Percent of healthy options placed in vending machines on hospital campus.

Existing Programs

Hospital-Based Healthy Lifestyles Programs

- Saint Mary's offers inpatient nutritional counseling and a significantly expanded outpatient nutritional counseling services that provide support groups and education.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2015, 131 patients had bariatric surgery.
- Saint Mary's has expanded and enhanced Cardiac Rehabilitation wellness program.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a program titled Mindful by Sodexo that includes healthy and nutritious food options.
- Beginning in 2016, Saint Mary's now offers breastfeeding classes taught by a certified lactation consultant specifically for mothers returning to work.
- Saint Mary's was awarded a grant to pilot the American College of Cardiology Nurse Navigator Program in 2014. Since then, the pilot has expanded into the PUMP Club; this program provides patients with Congestive Heart Failure education and coordination of post-acute care services.
- In 2016, Saint Mary's Hospital achieved its Chest Pain Center Accreditation with Primary PCI and Resuscitation from the American College of Cardiology Accreditation Services (formerly Society of Cardiovascular Patient Care).
- In 2016, Saint Mary's added a new Diabetes and Endocrinology Center.

Grant-Funded

- Saint Mary's is also a grant recipient of the WISEWOMEN™ program which helps women understand and reduce their risk for heart disease and stroke by providing services and screenings to promote lasting heart healthy lifestyles.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.

Initiatives

- Evaluate ways to continue to improve meal choices and healthy vending options at the hospital.
- Enhance existing breast feeding policies and procedures through exploration of Baby Friendly designation.
- Continue to promote education about heart disease including preventions such as Early Heart Attack Care and Hands-Only CPR.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Explore potential to facilitate training for and hosting of American Diabetes Association's Live Well with Diabetes within the hospital network.

IV. Tobacco Use and Asthma

Goal: Become a leader in expanding our role with tobacco control to reduce illness, disability, and death related to tobacco use and secondhand smoke exposure. In addition, reduce the incidence and progression of asthma in the Greater Waterbury region.

Objectives:

- Following Connecticut Department of Public Health guidelines and Connecticut Hospital Association tools to reduce asthma hospitalizations and Emergency Department visits.
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase publicity of Saint Mary's tobacco and e-cigarette free environments.
- Enact process to collect data within Physician Network Organization on the percentage of adult patients screened for tobacco use and cessation intervention.

Key Indicators

- Number of patients that receive a tobacco screening.
- Number of patients who receive a smoking cessation referral.
- Number of patients who successfully complete smoking cessation counseling.
- Number of physicians participating in the Easy Breathing Program.

Existing Programs

- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.
- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- Continue to explore efforts Greater Waterbury Region Asthma Coalition and the statewide health improvement initiative by Connecticut Hospital Association.

Initiatives

- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.
- Support Regional Health Ministry in efforts on Tobacco 21, Smoke Free Movies and other tobacco control policies in the state of Connecticut
- Initiate and properly educate patients on Smoke Free Campuses including the use of E-cigarettes
- Upon implementation of new Electronic Health Record, report to Trinity Health System Office the number of patients screened for tobacco use and cessation intervention.
- Support Greater Waterbury Region Asthma Coalition in implementing Asthma Action Plan in Emergency Department.
- Increase education to patients regarding asthma triggers including poor air quality days and second-hand smoke.

V. Health Communications

Goal: As a member of the Greater Waterbury Health Improvement Partnership, Saint Mary's Hospital will be a leader in advancing the ability for quality health information and increase the target area's health literacy.

Objectives:

- Increase visibility of health and well-being programs in the Greater Waterbury community through various community tools and provider education
- Increase availability of Greater Waterbury Health Improvement Partnership reports and data

Key Indicators

- Number of people who engage in Greater Waterbury Health Improvement Partnership website and social media posts.

Existing Programs

- A communications workgroup has been formed within the Greater Waterbury Health Improvement Partnership.

Initiatives

- Assist with creation and promotion of Greater Waterbury Health Improvement Partnership website, social media and communication vehicles.

Appendix A: CHNA Implementation Plan Resources

Bridge to Success Community Partnership
Catholic Charities
Catholic Family Services
Chesprocott Health District
City of Waterbury
Community Health Centers, Inc.
Connecticut Community Foundation
End Hunger Connecticut
Family Services of Greater Waterbury
Greater Waterbury Health Improvement Partnership (GWHIP)
Harold Leever Regional Cancer Center
Healthcare without Harm
Local and national legislators
Malta House of Care
Neighborhood Housing Services of Waterbury
New Opportunities, Inc.
Pomperaug District Department of Health
Public and Private School Systems
StayWell Health Center, Inc.
Trinity Health
Trinity Health – New England
United Way of Greater Waterbury
Value Options
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Health Access Program
Waterbury Youth Services
Wellmore Behavioral Health

User, OHCA

From: Cotto, Carmen
Sent: Thursday, May 25, 2017 2:23 PM
To: Capone, Claudio
Cc: Roberts, Karen; User, OHCA
Subject: RE: Trinity Health -New England CON filing requirements

Hi Claudio,

We will get back to you on the matter of coordinating the due dates.

Meantime, please provide us with a reason for your request for an extension by no later than midday tomorrow, Friday, May 26, 2017.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Thursday, May 25, 2017 7:09 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Trinity Health -New England CON filing requirements

Hi Carmen…I spoke to Jennifer and Finance would like to keep the reporting on our current 6 months schedule October 1 – March 31st due May 31 and April-September due November 30. It should be the same for all TH-NE facilities.

That said, can we get a 2 week extension on our May 31st filing?

Thanks,

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 16, 2017 4:26 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio,

This is to follow up on our request below for feedback on our suggested wording to help coordinate the various required filings from Trinity Health-New England.

Last time we spoke you were waiting for Ms. Schneider's return from vacation to provide us with a feedback.

We need to hear from you prior to finalizing the wording in question.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
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Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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www.ct.gov/dph

From: Roberts, Karen
Sent: Friday, February 24, 2017 11:38 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio – the wording below is what OHCA staff is thinking will help to better coordinate the various required filings to OHCA from Trinity Health –New England for the three recent transfer of ownership agreed settlements. Before we have this put in an email from our Director, Kim Martone, please take a look and let us know if this will help TH-NE out with having less filing dates to hit for these three CONs. The yellow highlights show where the words "following the Closing Date" appear in the conditions and OHCA's clarifying statement appears then in Red/Bold. Thanks. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

I. Certain Agreed Upon Conditions from Docket Number 15-31979-CON, St. Francis/Trinity - CLOSING/TRANSACTION DATE WAS OCTOBER 1, 2015

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on SFCRHM's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, SFCRHM shall submit to OHCA its Capital Investment Plan detailing the proposed allocation of the $275 million capital investment commitment over the five-year period post-closing. The submitted plans shall account for the full $275M commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. SFCRHM shall submit written reports updating the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the Hospital's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by SFCRHM's Chief Financial Officer.

14. SFCRHM shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, SFCRHM shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual

Report. The written report shall be posted on SFCRHM Website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS NOVEMBER 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON NOVEMBER 30TH ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

II. Certain Agreed Upon Conditions from Docket Number 15-32002-CON, Johnson Memorial/Trinity - CLOSING/TRANSACTION DATE WAS JANUARY 1, 2016

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on New JMMC's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to New JMMC and New JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from New JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by New JMMC's Chief Financial Officer.

14. New JMMC and New JMH shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, New JMMC and New JMH shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual Report. The written report shall be posted on New JMMC website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS FEBRUARY 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON MAY 31ST ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

III. ***Certain Agreed Upon Conditions from Docket Number 15-32045-CON, St. Mary's/Trinity***
- CLOSING/TRANSACTION DATE WAS AUGUST 1, 2016

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL REMAINS DUE AT THIS TIME.

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and
    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL MAY BE FILED EACH MAY 31ST AND NOVEMBER 30TH AS SET FORTH IN CONDITION #8 AS REFERENCED WITHIN #7.

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

    In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    d. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

13. TH-NE shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, TH-NE shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, TH-NE shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, TH-NE shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, TH-NE shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 29.*

THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

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User, OHCA

From: Roberts, Karen
Sent: Friday, May 26, 2017 4:37 PM
To: Capone, Claudio
Cc: Cotto, Carmen; Clarke, Ormand; Martone, Kim; Cable, Kimberly (KCable@stfranciscare.org); User, OHCA
Subject: RE: Trinity Health -New England CON filing requirements

Hi Claudio – we have received your request below for additional time to file the required May 31st semi-annual reports for the three Trinity-related transfer of ownership CONs, as follows:

St. Francis – Trinity DN 15-31979-CON
Johnson – Trinity DN 15-32002-CON
St. Mary's –Trinity DN 15-32045-CON

We find it acceptable for the reason that you expressed in your email to Mr. Cotto on May 25th, to provide you with additional time to fulfill this filing for these three docket numbers, but we would appreciate it if the filings are received by end of business day on Wednesday, June 7th.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Thursday, May 25, 2017 7:09 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Trinity Health -New England CON filing requirements

Hi Carmen…I spoke to Jennifer and Finance would like to keep the reporting on our current 6 months schedule October 1 – March 31st due May 31 and April-September due November 30. It should be the same for all TH-NE facilities.

That said, can we get a 2 week extension on our May 31st filing?

Thanks,

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 16, 2017 4:26 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio,

This is to follow up on our request below for feedback on our suggested wording to help coordinate the various required filings from Trinity Health-New England.

Last time we spoke you were waiting for Ms. Schneider's return from vacation to provide us with a feedback.

We need to hear from you prior to finalizing the wording in question.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Roberts, Karen
Sent: Friday, February 24, 2017 11:38 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio – the wording below is what OHCA staff is thinking will help to better coordinate the various required filings to OHCA from Trinity Health –New England for the three recent transfer of ownership agreed settlements. Before we have this put in an email from our Director, Kim Martone, please take a look and let us know if this will help TH-NE out with having less filing dates to hit for these three CONs. The yellow highlights show where the words "following the Closing Date" appear in the conditions and OHCA's clarifying statement appears then in Red/Bold. Thanks. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

I. Certain Agreed Upon Conditions from Docket Number 15-31979-CON, St. Francis/Trinity - CLOSING/TRANSACTION DATE WAS OCTOBER 1, 2015

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on SFCRHM's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, SFCRHM shall submit to OHCA its Capital Investment Plan detailing the proposed allocation of the $275 million capital investment commitment over the five-year period post-closing. The submitted plans shall account for the full $275M commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. SFCRHM shall submit written reports updating the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the Hospital's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by SFCRHM's Chief Financial Officer.

14. SFCRHM shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, SFCRHM shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual

Report. The written report shall be posted on SFCRHM Website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS NOVEMBER 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON NOVEMBER 30TH ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

II. Certain Agreed Upon Conditions from Docket Number 15-32002-CON, Johnson Memorial/Trinity - CLOSING/TRANSACTION DATE WAS JANUARY 1, 2016

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on New JMMC's website page.
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    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
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    c. Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from New JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by New JMMC's Chief Financial Officer.

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THIRTY DAYS OF THE CLOSING DATE IS FEBRUARY 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON MAY 31ST ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

III. ***Certain Agreed Upon Conditions from Docket Number 15-32045-CON, St. Mary's/Trinity***
- CLOSING/TRANSACTION DATE WAS AUGUST 1, 2016

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL REMAINS DUE AT THIS TIME.

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

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    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL MAY BE FILED EACH MAY 31ST AND NOVEMBER 30TH AS SET FORTH IN CONDITION #8 AS REFERENCED WITHIN #7.

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

    In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    d. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

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THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

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User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Wednesday, June 07, 2017 3:47 PM
To: User, OHCA; Cotto, Carmen; Roberts, Karen
Cc: Schneider, Jennifer; John Rodis; Kyle Jurczyk; Janeanne C. Lubin-Szafranski
Subject: Trinity Health - New England Conditions of CON Filings
Attachments: Saint Francis Trinity Health order requirements Summary of Cost Saving ....pdf; Saint Francis Trinity Health order requirements Summary of Cost Saving draft v1.docx; Johnson Trinity Health New England 5-30 order requirements.pdf; Attachment C Supplemental Stats for JMH.XLSX; Attachment A Detail of 6 month savings 10-1-2016 to 3-31-2017.xlsx; Attachment B JMH report 100-150.xlsx; Saint Mary's Key CON stats Mar 2017.xlsx; Saint Mary's Capital Exp - FA OCHA Info thur MAR17.xlsx; Saint Mary's Report 100_150_300_350_March 2017.xlsx; 15_31979 Attachment C TH-NE Financial Statistics -Mar 17- comp to Sept 16.xlsx; 15_31979 Attachment B2 Cashflow.xls; 15_31979 Attachment B1 TH-NE - CT - SAFNS - Reports 100 150 300 350 3.31.17.xlsx; 15_31979 Attachment A Detail of 6 month savings 3-31-2016.xlsx

Importance: High

Hello,

Attached are Trinity Health – New England's June 7th filings pursuant to our CON Conditions as delineated in Docket Numbers:

- 15-31979-CON, St. Francis/Trinity
- 15-32002-CON, Johnson Memorial/Trinity
- 15-32045-CON, St. Mary's/Trinity

Please feel free to contact me with any questions you may have regarding the attached.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning and Business Development
Trinity Health - New England

claudio.capone@trinityhealth-ne.org
W 860-714-6165
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1000 Asylum Avenue, 4th Floor
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delete it from your computer system. Saint Francis Hospital and Medical Center has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended March 31, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost saving opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Additional interest expense savings for the six months ended March 31, 2017 was approximately $226,000 as a result of favorable interest rates.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This created an overall decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. The benefit related to this change was $650,000 for the six month period ended 3/31/2017. In addition, Saint Francis will realize an additional annual savings in insurance premiums of $1.8 million effective 7/1/2017.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans, Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis recognized an annual benefit in pension expense of $4.2 million for the twelve month period

ended September 30, 2016. For the period from October 1, 2016 to March 31, 2017 the realized benefit was $2.3 million. Furthermore, Trinity and Saint Francis have developed a plan to continue to adequately fund the Saint Francis defined benefit plan consistent with the Trinity Health funding policy. Based on the current obligations under the plan and current funding level, Saint Francis will make contributions of $32.9 million to the plan during the period 7/1/2017-6/30/2018. Historically, Saint Francis was only able to contribute approximately $9 million to the plan annually.

Just prior to Saint Francis joining Trinity Health, a class action lawsuit was brought against Saint Francis relating to the question as to whether Saint Francis' defined benefit plan should be administered as a qualified "church plan" or a plan subject to Employee Retirement Income Security Act (ERISA). Trinity Health system office risk management collaborated with local leadership and was instrumental in resolving this matter. Furthermore, $800,000 of legal fees associated with this matter was paid for by Trinity Health on behalf of Saint Francis.

In January 2017, the employees of Saint Francis were brought onto to Trinity Health benefit programs which provided several enhancements to their benefits. The most significant change is that colleagues working more than twenty hours per week are participating in a defined contribution retirement program which provides a base core contribution of 3% for everyone and a matching contribution for the first 6% of a colleague's contribution. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Saint Francis continues with the transition to the Trinity Health Group Purchasing Organization, HPG. During the period October 1, 2016 to March 31, 2017, this effort has resulted in net supply chain savings of approximately $1.7 million. Most of the current saving was achieved by reducing the cost on existing goods through the implementation of the Trinity Health National Agreements. Other contract savings were realized with various revenue cycle vendors and totaled $219,000 during the same period. Supply Chain integration activity will continue in FY17 and FY18.

Trinity Health – New England, Inc. (TH – NE, formerly known as Saint Francis *Care*, Inc.), on behalf of its member hospitals including Saint Francis Hospital and Medical Center, Johnson Memorial Hospital and Saint Mary's Hospital, is currently working with Trinity Health on ensuring these hospitals continue to deliver high quality care and remain low cost providers within the community. TH-NE and Trinity Health have engaged external consultants to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.0 million benefit to the Connecticut hospitals within TH - NE.

Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings. Saint Francis continues to have a strong census as well as being recognized for its clinical excellence.

See **Attachment D.**

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,300
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$1,664
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$226
H.	Malpractice Insurance Cost	$650
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$219
	Total savings 10/1-3/31	$5,059

Attachment B1

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$14,863,000	($2,419,000)	-14%
2	Short Term Investments	$37,626,000	$22,759,000	($14,867,000)	-40%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$84,118,000	$19,529,000	30%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$36,994,000	($10,492,000)	-22%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$8,913,000	$8,964,000	$51,000	1%
8	Prepaid Expenses	$3,861,000	$2,797,000	($1,064,000)	-28%
9	Other Current Assets	$3,498,000	$3,950,000	$452,000	13%
	Total Current Assets	**$188,768,000**	**$175,120,000**	**($13,648,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$55,311,000	$56,453,000	$1,142,000	2%
2	Board Designated for Capital Acquisition	$42,931,000	$45,721,000	$2,790,000	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$0	($2,118,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$102,174,000**	**$1,814,000**	**2%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,935,000	($2,331,000)	-18%
6	Long Term Investments	$48,717,000	$51,061,000	$2,344,000	5%
7	Other Noncurrent Assets	$7,050,000	$8,864,000	$1,814,000	26%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$428,235,000	$9,424,000	2%
2	Less: Accumulated Depreciation	$43,734,000	$62,758,000	$19,024,000	43%
	Property, Plant and Equipment, Net	**$375,077,000**	**$365,477,000**	**($9,600,000)**	**-3%**
3	Construction in Progress	$14,905,000	$28,823,000	$13,918,000	93%
	Total Net Fixed Assets	**$389,982,000**	**$394,300,000**	**$4,318,000**	**1%**
	Total Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$30,624,000	($3,539,000)	-10%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,397,000	($6,747,000)	-18%
3	Due To Third Party Payers	$8,953,000	$7,509,000	($1,444,000)	-16%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$6,690,000	($235,000)	-3%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$9,764,000	$719,000	8%
	Total Current Liabilities	**$97,230,000**	**$85,984,000**	**($11,246,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$235,217,000	($2,515,000)	-1%
	Total Long Term Debt	**$237,732,000**	**$235,217,000**	**($2,515,000)**	**-1%**
3	Accrued Pension Liability	$227,408,000	$209,405,000	($18,003,000)	-8%
4	Other Long Term Liabilities	$51,868,000	$52,668,000	$800,000	2%
	Total Long Term Liabilities	**$517,008,000**	**$497,290,000**	**($19,718,000)**	**-4%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$70,673,000	$21,451,000	44%
2	Temporarily Restricted Net Assets	$29,372,000	$32,054,000	$2,682,000	9%
3	Permanently Restricted Net Assets	$55,311,000	$56,453,000	$1,142,000	2%
	Total Net Assets	**$133,905,000**	**$159,180,000**	**$25,275,000**	**19%**
	Total Liabilities and Net Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,000	$1,225,669,000	($1,026,535,000)	-46%
2	Less: Allowances	$1,498,710,000	$828,362,000	($670,348,000)	-45%
3	Less: Charity Care	$8,463,000	$9,103,000	$640,000	8%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,000**	**$388,204,000**	**($356,827,000)**	**-48%**
5	Provision for Bad Debts	$14,575,000	$8,642,000	($5,933,000)	-41%
	Net Patient Service Revenue less provision for bad debts	**$730,456,000**	**$379,562,000**	**($350,894,000)**	**-48%**
6	Other Operating Revenue	$38,574,000	$18,266,000	($20,308,000)	-53%
7	Net Assets Released from Restrictions	$3,397,000	$1,993,000	($1,404,000)	-41%
	Total Operating Revenue	**$772,427,000**	**$399,821,000**	**($372,606,000)**	**-48%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$258,412,000	$122,840,000	($135,572,000)	-52%
2	Fringe Benefits	$63,421,000	$27,879,000	($35,542,000)	-56%
3	Physicians Fees	$52,062,000	$22,292,000	($29,770,000)	-57%
4	Supplies and Drugs	$115,390,000	$65,971,000	($49,419,000)	-43%
5	Depreciation and Amortization	$44,179,000	$19,210,000	($24,969,000)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$8,115,000	$4,421,000	($3,694,000)	-46%
8	Malpractice Insurance Cost	$8,753,000	$4,721,000	($4,032,000)	-46%
9	Other Operating Expenses	$211,691,000	$115,900,000	($95,791,000)	-45%
	Total Operating Expenses	**$762,023,000**	**$383,234,000**	**($378,789,000)**	**-50%**
	Income/(Loss) From Operations	**$10,404,000**	**$16,587,000**	**$6,183,000**	**59%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,882,000	$4,945,000	($1,937,000)	-28%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,960,000)	($421,000)	$4,539,000	-92%
	Total Non-Operating Revenue	**$1,922,000**	**$4,524,000**	**$2,602,000**	**135%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Principal Payments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$72,316,000	$49,467,000	($22,849,000)	-32%
2	Short Term Investments	$49,401,000	$30,955,000	($18,446,000)	-37%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$124,168,000	$137,830,000	$13,662,000	11%
4	Current Assets Whose Use is Limited for Current Liabilities	$5,754,000	$0	($5,754,000)	-100%
5	Due From Affiliates	$3,147,000	$6,481,000	$3,334,000	106%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$14,316,000	$15,242,000	$926,000	6%
8	Prepaid Expenses	$8,569,000	$7,391,000	($1,178,000)	-14%
9	Other Current Assets	$13,155,000	$13,435,000	$280,000	2%
	Total Current Assets	**$296,339,000**	**$261,476,000**	**($34,863,000)**	**-12%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$71,841,414	$73,184,000	$1,342,586	2%
2	Board Designated for Capital Acquisition	$67,971,586	$72,277,000	$4,305,414	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$24,717,000	$0	($24,717,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$164,530,000**	**$145,461,000**	**($19,069,000)**	**-12%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$52,748,000	$58,285,000	$5,537,000	10%
7	Other Noncurrent Assets	$18,518,000	$17,556,000	($962,000)	-5%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$551,097,000	$570,246,000	$19,149,000	3%
2	Less: Accumulated Depreciation	$49,168,000	$79,463,000	$30,295,000	$1
	Property, Plant and Equipment, Net	**$501,929,000**	**$490,783,000**	**($11,146,000)**	**-2%**
3	Construction in Progress	$23,674,000	$40,973,000	$17,299,000	73%
	Total Net Fixed Assets	**$525,603,000**	**$531,756,000**	**$6,153,000**	**1%**
	Total Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$68,313,000	$63,707,000	($4,606,000)	-7%
2	Salaries, Wages and Payroll Taxes	$75,613,000	$67,903,000	($7,710,000)	-10%
3	Due To Third Party Payers	$15,903,000	$16,154,000	$251,000	2%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,821,000	$7,479,000	($342,000)	-4%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$11,999,000	$13,487,000	$1,488,000	12%
	Total Current Liabilities	**$179,649,000**	**$168,730,000**	**($10,919,000)**	**-6%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$256,156,000	$253,458,000	($2,698,000)	-1%
	Total Long Term Debt	**$256,156,000**	**$253,458,000**	**($2,698,000)**	**-1%**
3	Accrued Pension Liability	$314,044,000	$288,664,000	($25,380,000)	-8%
4	Other Long Term Liabilities	$79,162,000	$61,880,000	($17,282,000)	-22%
	Total Long Term Liabilities	**$649,362,000**	**$604,002,000**	**($45,360,000)**	**-7%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$123,226,000	$132,238,000	$9,012,000	7%
2	Temporarily Restricted Net Assets	$33,642,000	$36,380,000	$2,738,000	8%
3	Permanently Restricted Net Assets	$71,859,000	$73,184,000	$1,325,000	2%
	Total Net Assets	**$228,727,000**	**$241,802,000**	**$13,075,000**	**6%**
	Total Liabilities and Net Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,903,594,000	$1,990,018,000	($913,576,000)	-31%
2	Less: Allowances	$1,902,814,000	$1,329,832,000	($572,982,000)	-30%
3	Less: Charity Care	$16,893,000	$14,729,000	($2,164,000)	-13%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$983,887,000**	**$645,457,000**	**($338,430,000)**	**-34%**
5	Provision for Bad Debts	$21,382,000	$16,997,000	($4,385,000)	-21%
	Net Patient Service Revenue less provision for bad debts	**$962,505,000**	**$628,460,000**	**($334,045,000)**	**-35%**
6	Other Operating Revenue	$48,990,000	$36,152,000	($12,838,000)	-26%
7	Net Assets Released from Restrictions	$7,991,000	$2,494,000	($5,497,000)	-69%
	Total Operating Revenue	**$1,019,486,000**	**$667,106,000**	**($352,380,000)**	**-35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$447,852,000	$314,233,000	($133,619,000)	-30%
2	Fringe Benefits	$94,930,000	$52,558,000	($42,372,000)	-45%
3	Physicians Fees	$33,406,000	$24,902,000	($8,504,000)	-25%
4	Supplies and Drugs	$162,109,000	$107,533,000	($54,576,000)	-34%
5	Depreciation and Amortization	$50,735,000	$30,251,000	($20,484,000)	-40%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$9,056,000	$5,047,000	($4,009,000)	-44%
8	Malpractice Insurance Cost	$12,300,000	$9,480,000	($2,820,000)	-23%
9	Other Operating Expenses	$212,471,000	$114,986,000	($97,485,000)	-46%
	Total Operating Expenses	**$1,022,859,000**	**$658,990,000**	**($363,869,000)**	**-36%**
	Income/(Loss) From Operations	**($3,373,000)**	**$8,116,000**	**$11,489,000**	**-341%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$5,917,000	$6,960,000	$1,043,000	18%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$54,901,000	($448,000)	($55,349,000)	-101%
	Total Non-Operating Revenue	**$60,818,000**	**$6,512,000**	**($54,306,000)**	**-89%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**
	Other Adjustments:				

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 21,111,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**19,210,000**
Bad debts	**8,642,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,682,000**
Equity transfer	**340,000**
Changes in:	
Accounts receivable--patients, net	**(28,171,000)**
Due from affiliated entities	**10,492,000**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(51,000)**
Prepaid expenses	**1,064,000**
Other assets	**(2,266,000)**
Accounts payable	**(3,539,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(6,747,000)**
Due to third party reimbursement agencies	**(1,444,000)**
Other current liabilities	**719,000**
Accrued pension and retiree health costs	**(18,003,000)**
Other long term liabilities	**800,000**
Net cash provided by operating activities	**10,819,000**
Investing activities:	
Purchases of property, plant and equipment, net	**(23,528,000)**
Decrease in assets whose use is limited	**(1,814,000)**
Decrease in investments	**14,854,000**
Net cash used in investing activities	**(10,488,000)**
Financing activities	
Principal payments on long-term debt	**(2,750,000)**
Net cash used in financing activities	**(2,750,000)**
Net decrease in cash and cash equivalents	**(2,419,000)**
Cash and cash equivalents at beginning of period	**17,282,000**
Cash and cash equivalents at end of period	**14,863,000**

TRINITY HEALTH - NEW ENGLAND, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 14,628,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**30,251,000**
Bad debts	**16,997,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,738,000**
Equity transfer	**(5,433,000)**
Changes in:	
Accounts receivable--patients, net	**(30,659,000)**
Due from affiliated entities	**(3,334,000)**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(926,000)**
Prepaid expenses	**1,178,000**
Other assets	**682,000**
Accounts payable	**(4,606,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,710,000)**
Due to third party reimbursement agencies	**251,000**
Other current liabilities	**1,488,000**
Accrued pension and retiree health costs	**(25,380,000)**
Other long term liabilities	**(17,282,000)**
Net cash used in operating activities	**(21,137,000)**
Investing activities:	
Purchases of property, plant and equipment, net	**(36,404,000)**
Decrease in assets whose use is limited	**24,823,000**
Decrease in investments	**12,909,000**
Net cash provided by investing activities	**1,328,000**
Financing activities	
Principal payments on long-term debt	**(3,040,000)**
Net cash used in financing activities	**(3,040,000)**
Net decrease in cash and cash equivalents	**(22,849,000)**
Cash and cash equivalents at beginning of period	**72,316,000**
Cash and cash equivalents at end of period	**49,467,000**

Saint Francis Hospital and Medical Center

		Mar 17 YTD		Sept 16 YTD		Comments
Monthly Financial Measurement/Indicators						
A.	**Operating Performance:**					
	Operating Margin		4.1%		1.3%	operating income/operating revenues
	Non-Operating Margin		NA		NA	
	Total Margin		10.1%		8.1%	Operating cash flow margin (EBIDA/operating revenue)
	Bad Debt as % of Gross Revenue		0.7%		0.6%	bad debt/total patient serv. Revenue(before allowances)
B.	**Liquidity:**					
	Current Ratio		2.0		1.9	current assets/current liabilites
	Days Cash on Hand		41.7		49.7	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
	Days in Net Accounts Receivables		39.4		33.9	net ar/net patient ser rev(after bd)/days in yr
	Average Payment Period		43.0		44.1	current liabilities/(total exp-depr)/YTD days in yr
C.	**Leverage and Capital Structure:**					
	Long-term Debt to Equity		152.0%		182.7%	total debt/total equity(net assets)
	Long-term Debt to Capitalization		59.6%		64.0%	LTD/LTD+net assets
	Unrestricted Cash to Debt		34.5%		40.0%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
	Times Interest Earned Ratio		4.8		2.3	EBIT/Interest expense
	Debt Service Coverage Ratio		3.6 x		4.2 x	(Net income+int+depr)/(st debt+int exp)
	Equity Financing Ratio		21.4%		17.9%	Net assets/total assets
D.	**Additional Statistics (in thousands)**					
	Income(Loss) from Operations	$	16,587	$	10,404	Net income(loss) from operations
	Revenue Over/(Under) Expense	$	21,111	$	12,326	Net gain(loss)
	EBITDA	$	40,218	$	62,698	based on net income(loss) from operations
	Patient Cash Collected		NA		NA	
	Cash and Cash Equivalents	$	37,622	$	54,908	from cons bs
	Net Working Capital	$	89,136	$	91,538	current assets-current liabilities
	Unrestricted Assets	$	70,673	$	49,222	from cons bs

Source=SAFNS reports 100 150 300 350 331

Trinity Health - New England, Inc (Formerly Saint Francis Care, Inc.)

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	(0.3%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.5%	5.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	1.6	1.6	current assets/current liabilites
Days Cash on Hand	44.2	71.2	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	38.9	46.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.8	67.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	107.9%	115.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	51.2%	52.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	0.6	0.7	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.6	0.6	EBIT/Interest expense
Debt Service Coverage Ratio	3.5 x	3.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	23.8%	21.6%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 8,116	$ (3,373)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 14,628	$ 57,445	Net gain(loss)
EBITDA	$ 43,414	$ 56,418	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 80,422	$ 121,717	from ct0cons hfm
Net Working Capital	$ 92,746	$ 116,690	current assets-current liabilities
Unrestricted Assets	$ 132,238	$ 123,226	from ct0cons hfm

Saint Francis Awards, Accreditations and Recognitions
Fiscal Year 2016 and 2017

Connecticut Joint Replacement Institute ISO 9001:2015 Certified
The Connecticut Joint Replacement Institute at Saint Francis Hospital and Medical Center (CJRI) has been recertified in compliance with the International Standards Organization's (ISO) 9001:2015 standard for health care. First certified in 2014 as an ISO 9001:2008 Quality Management System compliant organization, the Connecticut Joint Replacement Institute (CJRI) remains the only health care facility in Connecticut to be compliant with ISO standards. There are approximately 500 health care providers nationwide with this distinction. The three-year re-certification is awarded by DNV-GL Certification Inc., of Houston, TX, following an intensive audit of CJRI's workflows, quality and safety measurement tools. (Feb. 2017)

2017 Women's Choice Award® as one of America's Best Hospitals for Heart Care
Saint Francis Hospital and Medical Center has been named one of America's Best Hospitals for Heart Care by the Women's Choice Award®, America's trusted referral source for the best in healthcare. The award signifies that Saint Francis Hospital and Medical Center is in the top 9% of 4,789 U.S. hospitals offering heart care services. (Jan. 2017)

2017 Women's Choice Award®, America's Best Hospitals for Bariatric Surgery
Saint Francis Hospital and Medical Center has been named as one of America's Best Hospitals for Bariatric Surgery by the Women's Choice Award®, America's trusted referral source for the best in healthcare. The award signifies that Saint Francis Hospital and Medical Center is in the top 8% of 4,789 U.S. hospitals reviewed. This is the second consecutive year that Saint Francis Hospital and Medical Center has received the Women's Choice Award for Bariatric Surgery. (Jan. 2017)

2017 Women's Choice Award®, America's Best Hospitals for Obstetrics
Saint Francis Hospital and Medical Center has been named as one of America's Best Hospitals for Obstetrics by the Women's Choice Award®, America's trusted referral source for the best in health care. The award signifies Saint Francis Hospital and Medical Center is in the top 17% of 2,815 U.S. hospitals offering obstetrics. (Jan. 2017)

Electronic Medical Record Adoption Model (EMRAM) Stage 7 Award
In recognition of its collaboration among operational, IT resources and partnering vendors to create the best system for delivering care to their patients, Saint Francis Hospital and Medical Center has been awarded with the Electronic Medical Record Adoption Model (EMRAM) Stage 7 Award. Saint Francis collaborated with a specialized niche electronic medical record (EMR) software company and one large vendor to build, test workflow, study, report and exchange data between the two systems. (Nov. 2016)

Transforming Communities Initiative
Saint Francis Hospital and Medical Center, through the Curtis D. Robinson Center for Health Equity, launched the Transforming Communities Initiative that will unite health care systems, community groups and development agencies to address health disparities in Hartford's North End. The Transforming Communities Initiative will bring together Saint Francis, the City of Hartford and Community Solutions to develop programs and strategies aimed at reducing obesity, promoting tobacco-free living, and addressing social determinants that impact current and future health outcomes for the people of the North End of Hartford.

Saint Francis is the second Trinity Health – New England provider to be chosen to be part of a larger Transforming Communities Initiative launched by Trinity Health. The first six participants announced in April included Mercy Medical Center. Over the next five years, Trinity Health will invest approximately $80 million in grants, loans, community match dollars and services in those communities.

"A" Rating for the Leapfrog Group
Saint Francis Hospital and Medical Center is one of only six hospitals in the state designated with an "A" safety score rating by the Leapfrog Group. This is the 8th "A" rating since 2012, something no other hospital has attained. The Hospital Safety Score℠ grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. The grades are derived from analysis of publicly available data using evidence-based, national measures of hospital safety. Leapfrog assigned scores to more than 2,500 hospitals nationwide, including 27 hospitals in Connecticut.

Becker's Hospital Review - "100 Hospitals with Great Orthopedic Programs"
Saint Francis Hospital and Medical Center has been named to Becker's Hospital Review 2016 list recognizing it as one of the "100 Hospitals with Great Orthopedic Programs" in the United States. Saint Francis is the only Connecticut hospital on the list and appears for the third consecutive year.

Women's Choice Award
Saint Francis Hospital and Medical Center has received the 2016 Women's Choice Award® as one of America's Best Breast Centers. This evidence-based designation is the only award that identifies the country's best breast centers based on robust criteria that considers female patient satisfaction and clinical excellence. The list of over 374 award winners, including the Maximilian E. and Marion O. Hoffman Foundation Breast Health Center at Saint Francis, represents breast centers that have met the high standards of the National Accreditation Program for Breast Centers (NAPBC) and carry the Breast Imaging Center of Excellence (BICOE) seal from the American College of Radiology. They have also scored above the national average on the Centers for Medicare and Medicaid Services patient recommendation measures, or their equivalent.

Johnson Memorial Hospital

		Mar 17 YTD		Sept16* YTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin		1.2%		-7.0%	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		6.4%		-0.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		1.3%		1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		0.8		0.8	current assets/current liabilites
Days Cash on Hand		15.5		9.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables		76.9		109.4	net ar/net patient ser rev/days in yr
Average Payment Period		164.0		186.9	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		823.7%		-402.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization		89.0%		133.8%	LTD/LTD+net assets
Unrestricted Cash to Debt		8.1%		7.5%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		2.0		(4.5)	EBIT/Interest expense
Debt Service Coverage Ratio		2.59 x		-0.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		6.1%		-11.3%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations*	$	399	$	(3,214)	Net income(loss) from operations
Revenue Over/(Under) Expense	$	350	$	(3,474)	Net gain(loss)
EBIDA	$	2,107	$	(247)	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	1,766	$	1,696	from bs
Net Working Capital	$	(2,835)	$	(7,177)	current assets-current liabilities
Unrestricted Assets	$	2,084	$	(6,169)	from bs

*reflects 01/16-09/30/16

	Saint Mary's Health System (Consolidated)	Month		Year to Date	
		Mar 2017	Prior Year	Mar 2017	Prior Year
A.	**Operating Performance**				
	Operating Margin	7.3%	6.6%	2.4%	2.4%
	Non-Operating Margin	1.3%	-0.2%	0.3%	0.3%
	Total Margin	8.6%	6.4%	2.8%	2.7%
	Bad Debt as % of Gross Revenue	0.1%	1.3%	1.0%	1.3%
B.	**Liquidity**				
	Current Ratio	1.89	2.13	1.89	2.13
	Days Cash on Hand	26	24	26	24
	Days in Net Accounts Receivable	38	41	38	41
	Average Payment Period	50	55	50	55
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.01	0.24	0.01	0.24
	Long-term Debt to Capitalization	0.01	0.20	0.01	0.20
	Unrestricted Cash to Debt	28.23	1.44	28.23	1.44
	Times Interest Earned Ratio	595.9	86.4	209.20	33.87
	Debt Service Coverage Ratio	14.0	11.5	8.38	6.64
	Equity Financing Ratio	2.63	3.85	2.63	3.85
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 2,044	$ 1,854	$ 3,871	$ 3,725
	Revenue Over/(Under) Expense	$ 2,398	$ 1,807	$ 4,411	$ 4,199
	EBITDA	$ 3,512	$ 2,872	$ 12,568	$ 9,959
	Patient Cash Collected	$ 27,894	$ 28,833	$ 149,302	$ 148,473
	Cash and Cash Equivalents	$ 20,937	$ 19,016	$ 20,937	$ 19,016
	Net Working Capital	$ 23,409	$ 25,933	$ 23,409	$ 2,533
	Unrestricted Assets	$ 60,607	$ 36,777	$ 606,607	$ 36,777
	Credit Ratings (S&P, FITCH and Moody's)				

Source=SAFNS reports 100 150 300 350 3311

Trinity Health - New England, Inc (Formerly Saint Francis Care, Inc.)

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	(0.3%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.5%	5.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	1.6	1.6	current assets/current liabilites
Days Cash on Hand	44.2	71.2	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	38.9	46.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.8	67.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	107.9%	115.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	51.2%	52.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	0.6	0.7	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.6	0.6	EBIT/Interest expense
Debt Service Coverage Ratio	3.5 x	3.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	23.8%	21.6%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 8,116	$ (3,373)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 14,628	$ 57,445	Net gain(loss)
EBITDA	$ 43,414	$ 56,418	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
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Net Working Capital	$ 92,746	$ 116,690	current assets-current liabilities
Unrestricted Assets	$ 132,238	$ 123,226	from ct0cons hfm

Saint Francis Hospital and Medical Center

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	4.1%	1.3%	operating income/operating revenues
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Times Interest Earned Ratio	4.8	2.3	EBIT/Interest expense
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Equity Financing Ratio	21.4%	17.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 16,587	$ 10,404	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 21,111	$ 12,326	Net gain(loss)
EBITDA	$ 40,218	$ 62,698	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 37,622	$ 54,908	from cons bs
Net Working Capital	$ 89,136	$ 91,538	current assets-current liabilities
Unrestricted Assets	$ 70,673	$ 49,222	from cons bs

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$1,675
B.	Fringe Benefits (workers comp)	$335
C.	Contractual Labor Fees	($1,204)
D.	Medical Supplies and Pharmaceutical Cost	$75
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$30
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$114
K.	Other Operating Expense	$373
	Total savings 10/1/2016-3/31/2017	$1,398

DESCRIPTION	DEPT	QUAN	CLASS	TYPE	ACQ DATE	ENTRY PER
FABIUSTIRO ANESTHESIA MACHINES	7220	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
INTELLIVUE MONITORS & ACCESSORIES	7220	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
STERILIZATION CONTAINER	7570	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
ISTAT 1 WIRELESS ANALYZER	7361	3	MOVEABLE	MEDICAL	8/31/2016	11/2016
SCOPES 0 DEG & 30 DEG CURETTATE	7850	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
VC- 10 VACUUM	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
BLADDER SCAN BVI 9400	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
LIPOSCULTPTOR & ACCESSORIES	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
SUTURE RETRIEVER ACCESSORIES	7850	40	MOVEABLE	MEDICAL	8/31/2016	11/2016
SCOPE HOPKINS 11 30 DEG	7850	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
B3000 BLACK BADGE & BATTERIES	7010	40	MOVEABLE	MEDICAL	8/31/2016	11/2016
CO2 MONITOR & ACCESSORIES	7540	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
ARTIC SUN 5000E TEMP	6500	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
OPTIPLEX 7040 PC & MONITORS	9080	10	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
BUILDING SIGN	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
CONDENSING UNIT	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
HVAC CLEANING & SANTIZING	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
FIRE & SMOKE DAMPER	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
FLOOR SCRUBBERS SINGLE & DUAL	8100	2	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
DEHUMIDIFIER TRAGER BASEMENT	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
EXPANSION VALVE TRAGER	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
WALL COVERING - AUDITORIUM	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
COOLONG COL REPLACEMENT	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
CATH LAB # 2 RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
SLEEP LAB RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
BOARDROOM RENOVATION	9000	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
10 FT HOSES	7540	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
REVERSE OSMOSIS SYSTEM	7010	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
HARMONYAIR LIGHT SYSTEM	7070	1	FIXED	NONMEDICAL	8/31/2016	11/2016
RECUMBENT CROSS TRAINER	7420	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CONTAINERS FOR STERILIZATION	7570	75	MOVEABLE	MEDICAL	9/30/2016	12/2016
TITANIUM GE MRI TOOL KIT	8320	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
LIPOTOWER ASPIRATOR / INFIL	7850	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CART, SINGLE TIER CORNER	7280	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CAMERA, CODER & STORAGE	8350	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
VOLUSON P8	7070	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CARBON FIBER BOARD	7460	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
CHESHIRE UC INSTALL	7700	1	FIXED	NONMEDICAL	9/30/2016	12/2016
DELL OPTOPLEX 7040	9080	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
MARKETING FURNITURE	9190	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016

NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
COUNTER FOR PSYCHIATRIC WARD	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
FEASABILITY STUDY OPEN OFFICE	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
COUNTER TOPS THROUGHOUT HOSPITAL	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
AUDITORIUM RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
FIRE STOP	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
MAIN MEGAWATT METER REPLACEMENT	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
EPOXY COATED SHOWER BASE	8300	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
BLASIUS 2014 CHEVROLET CRUZE	7361	1	AUTO	NONMEDICAL	9/30/2016	12/2016
SLEEP LAB BUDGETED CONTRACT	7980	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
MEP	7980	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
RODI PIPING & INSTALL	7010	1	FIXED	NONMEDICAL	9/30/2016	12/2016
SEER 1000	7901	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
MAMMOTEST	7280	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
EMERGENCY TEMP WALL	8300	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
FURNISH & INSTALL CARPET & TILE	7850	1	FIXED	NONMEDICAL	10/31/2016	01/2017
DAYCARE REMEDIATION	8460	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
BRIO BEDSIDE CABINETS & OVERHEAD ART	7180	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
AAON RTU GAS METERING	8300	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
SYNGO DYNAMICS SYSTEM	9080	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
REMOVE OLD HTP/ PUT NEW IN ITS PLACE	8300	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
BRAINLAB OPTICAL	7010	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
V500 WORKSTATIONS	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
SMART CARE MONITORING	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
AQUILLION PRIME 80	7280	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
MOB 4TH FLOOR LOBBY	8300	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
FLEX-X UTRETERSCOPE	7010	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
SLEEP DESIGN MOB	7980	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
CDIS MULTIGROUPING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
LICENSE/ SUPPORT/ TRAINING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
CARBON FIBER BOARD	7460	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
TRANSDUCER CONVEX & LINEAR	7461	2	MOVEABLE	MEDICAL	11/30/2016	02/2017
OR ROOM REPAIRS	7010	1	FIXED	NONMEDICAL	11/30/2016	02/2017
DEHUMIDIFIER INSTALL - TRAGER	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
VIDEO INTERCOM	7980	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
SOFTWARE LICENSE FEES	8400	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
DOOR ACCESS SYSTEM	8460	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
HARMONY LIGHTS/ FP	7850	7	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
CABLING	7980	1	FIXED	NONMEDICAL	10/31/2016	01/2017
CABINET & SHELVES	8300	8	FIXED	NONMEDICAL	11/30/2016	02/2017
FRAME NEW WALL	8300	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CABINETS	7850	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CIRCUIT FOR INBND/OUTBND SWITCHING	8300	1	FIXED	NONMEDICAL	11/30/2016	02/2017
DISPOSABLE LINERS	8100	24	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
PCKGO HEAT EXCHGE/PUMP REPLACEMENT	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
SLEEP LAB PROJECT	7980	1	FIXED	NONMEDICAL	11/30/2016	02/2017

SLEEP LAB PROJECT	7980	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CARPET CHILD DEV	8460	1	FIXED	NONMEDICAL	11/30/2016	02/2017
INTUITIVE ROBOT BUYOUT	7010	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
EV100 CLINICAL PLTFM & SERVICE	7220	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
EV100 CLINICAL PLTFM & SERVICE	6510	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
FURNISH & INSTALL CARPET & TILE	7850	1	FIXED	NONMEDICAL	11/30/2016	02/2017
FURNITURE	9170	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
DOUBLE CATCH BASIN	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- BLOCK WINDOWS IN LAWLOR	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- CONSTRUCTION PROCESS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- FLOORING VINYL	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- DUCTWORK & EXHAUST FANS INSTAL	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- ELECTRICAL CONTROLS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- PAINTING STAIRWELLS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- SECURITY WORK SPACE	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
911 PJT- STRIPPING AND WAXING FLOORS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- INTERIOR SIGNS	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
911 PJT-ACCESS CONTROL SYSTEM	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT-SPRINKLER HEADS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
INTERIOR SIGN BRAILLE	7980	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
V500 WORKSTATIONS	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
1320 WEST MAIN ADDITION	8300	1	BLD IMP	NONMEDICAL	12/31/2016	03/2017
BOLLAND AT OXYGEN TANKS REMOVE & INSTA	8300	1	LAND IMP	NONMEDICAL	12/31/2016	03/2017
4 FT POS PRESS RECIRC COMP	7120	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
HARMONY DUAL & SINGLE LIGHTING	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
DR TRAGER NEW FLOOR & FURNITURE	9831	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
ULTRASOUND SPARQ	7290	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ATRION TELEPHONE SYSTEM	9100	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
LIFE POLE W/LIFT & ASSIST	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
BRAVO RECEIVER/SOFTWARE/RECORDER	7850	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
PROFESSIONAL DESIGN	8300	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
TITAN 450 WATT ZENON LIGHT	7010	3	MOVEABLE	MEDICAL	12/31/2016	03/2017
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
CDIS TRAINNG/LICENSE	8400	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
ATOMLAB 500 DOSE CALIB	7630	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ULTRAFIN LITHO STIRUP PAIR	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
IS4000 DA VINCI XI	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
STERRAD 100NX ™	7570	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
SEER 1000	7901	6	MOVEABLE	MEDICAL	12/31/2016	03/2017
WEST MAIN TRANSFORMER RELOCATION	8300	1	FIXED	NONMEDICAL	12/31/2016	03/2017
ROBOTIC CARRIER FOR NIGARA	7570	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
FLOORING	7010	1	FIXED	NONMEDICAL	12/31/2016	03/2017
BASE BID	8300	1	FIXED	NONMEDICAL	12/31/2016	03/2017
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL	12/31/2016	03/2017
PROFUSION UPGRADE	9080	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
CADAVER LIFT CONVEYOR	7361	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ENTERAL SYRINGE PUMP	6750	3	MOVEABLE	MEDICAL	12/31/2017	03/2018

C0MPELLENT SC220 ENCLOSURE	9080	3	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
POWER LED 175 LIGHT SOURCE	7010	2	MOVEABLE	MEDICAL	12/31/2017	03/2018
NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
HP DL380 G9 8GB RAM	7280	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
LICENSE/ SOFTWARE/ SUPPORT	7010	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
POWEREDGE R730 SERVER	9080	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SHELVING	7180	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
COMPELLENT SC220 ENCLOSURE	9080	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
same						
same						
WEST MAIN ADDITION	8300	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
TRUSYSTEM 7000DV & ROBOTIC PKG	7010	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MOB SLEEP LAB RENOVATION	7980	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
PARKING GARAGE ASSESSMENT CONDITION	8300	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
LIGHTING UPGRADE	8300	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SUNQUEST PJT/ TV, DESK,ACCESS	7361	3	MOVEABLE	MEDICAL	1/31/2017	04/2017
same						
OR LIGHT SUPPORT SYSTEM	7070	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SHIMADZU PORTABLE X-RAY	7280	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
WALLS IN SLEEP LAB	7980	1	FIXED	NONMEDICAL	1/31/2017	04/2017
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
WARMING CABINET #5524	7340	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MOB 4TH FL LOBBY NEW WALL & DOOR	8300	1	FIXED	NONMEDICAL	1/31/2017	04/2017
FIRE ALARM PANEL	8300	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
O'BRIEN PLUMBING	8300	1	FIXED	NONMEDICAL	1/31/2017	04/2017
PACEMAKER EXTERNAL	6510	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
AQUILION CT SCAN PYMT	7280	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MONITORS, CAMERAS, LIGHT PKG	7010		MOVEABLE	MEDICAL	42094	6/2015
LICENSE/ SUPPORT/ TRAINING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
TABLE MOTION UPGRADE	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
FLOORING	7010	1	FIXED	NONMEDICAL	2/28/2017	05/2017
FLOORING	8300	1	FIXED	NONMEDICAL	2/28/2017	05/2017
GAS CHARBOILER INSTALL	8000	1	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
SERVERS	9080	4	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
PROFESSIONAL SERVICES WMUC	7903	1	BLDG IMP	NONMEDICAL	2/28/2017	05/2017
FIBROSCAN 502 TOUCH	7850	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
ACUSON SC2000 MAINFRAME	7220	1	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
CHAIRS, ALL STEEL TASK	7070	15	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
SPECTRUM IV PUMPS	7800	50	MOVEABLE	MEDICAL	2/28/2017	05/2017
same						
ADDITIONAL CAMERAS	8350	9	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
same						
SHELVING & CABINETS	7909	2	MOVEABLE	NONMEDICAL	2/28/2017	05/2017

BASE CABINET & COUNTERTOPS	7070	2	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
URETERSCOPE FLEXIBLE	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
SYNGO DYNAMICS SYSTEM	9080	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL	12/31/2016	03/2017
SOFTWARE SERVICES	7280	2	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
INFUSION ANALYZER	8320	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
APPLICATION & CERTIFICATE	7980	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
ARCHITECTUAL/MEP	7980	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
ARCHITECTUAL/MEP	7980		BLDG IMP	NONMEDICAL	3/31/2017	06/2017
TRIAGE PROJECT	8300	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
PF6001 MAIN UNIT	7550	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
FLOORING/INSTALL	7570	1	FIXED	NONMEDICAL	3/31/2017	06/2017
MARTINS ARM RETRACTOR	7010	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
ESPRESSO MACHINE	8000	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
UPGRADE VIRTUAL SIS SERVER	9080	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
SPECTRUM IV PUMPS	7800	30	MOVEABLE	MEDICAL	3/31/2017	06/2017
PIPE TESTING PJT 911	8300	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
MONITOR DEMOSURE SIGNVS4	6150	2	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
MONITOR DEMOSURE SIGNVS4	6130	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
DEPT OF MEDICINE DOOR	8300	1	FIXED	NONMEDICAL	3/31/2017	06/2017
FLEX-X URETERSCOPE	7010	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
INTELLIVUE MULTI SERVER	6500	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
PRINTER CONNEX 3D	8320	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
ASTER TEE (WATER & AIR) SYSTEM	7440	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
PROFESSIONAL SERVICES WMUC	7903	1	BLDG IMP	NONMEDICAL	2/28/2017	05/2017

LOCATION	AMT	VENDOR	PO	SCHEDULE 1	METHOD	EST MO.	
ANES	59,992.08	DRAEGER MED	1614690			60	Aug-16
ANES	50,254.20	PHILIPS 19413	1615589			60	Aug-16
NVSC	13,894.57	AESCULAP	1618025			84	Aug-16
LAB	28,060.47	ABBOTT LAB	1617180			60	Aug-16
NVSC	9,618.00	KARL STORZ	1616167			84	Aug-16
NVSC	5,205.50	OLYMPUS 17199	1616166			84	Aug-16
NVSC	18,316.00	VERATHON	1616110			84	Aug-16
NVSC	19,376.45	MICROAIRE	1616161			84	Aug-16
NVSC	38,916.00	ARTHREX	1616174			84	Aug-16
NVSC	9,300.40	KARL STORZ	1616164			84	Aug-16
OR	20,552.00	VOCERA	1616606			84	Aug-16
RESP	5,453.04	DRAEGER MED	1614719			120	Aug-16
CCU	50,494.00	BARD MED	1616616			84	Aug-16
IT	27,050.40	DELL - 18065	1616179			60	Aug-16
NVSC	2,200.00	CONNECTICUT SIGN	1615432			120	Aug-16
NVSC	23,316.00	SARRACCO	1614100			120	Aug-16
NVSC	23,203.50	STEAMATIC OF CT	1616595			60	Aug-16
PLANT	3,650.00	BRAND	1611712			120	Aug-16
PLANT	14,248.40	GRAINGER	1616342			60	Aug-16
PLANT	2,647.50	GOODHILL	1616795			60	Aug-16
PLANT	2,618.00	GOODHILL	1616840			60	Aug-16
PLANT	10,530.30	H2Z DESIGN	1615047			60	Aug-16
PLANT	45,350.00	MACRI	1609255			120	Aug-16
PLANT	70,203.36	O & G IND	1617840			120	Aug-16
PLANT	24,400.75	O & G IND	1617844			120	Aug-16
PLANT	18,518.50	ALL-PHASE	1512213			120	Aug-16
PRESP	647.44	DRAEGER MED	1614693			60	Aug-16
SURGERY	16,500.00	AMERICAN AQUA	1614998			84	Aug-16
WIC	49,805.83	STERIS	1616347			120	Aug-16
CARD REH	4,189.00	NUSTEP	1619582			84	Sep-16
CENTRAL STI	5,130.40	AESCULAP	1618052			84	Sep-16
CLINICAL	3,775.95	IMPREX INTERNATIONAL	1618781			84	Sep-16
NVSC	6,922.35	MICROAIRE	1616161			120	Sep-16
OR	295.92	STERIS	1618734			60	Sep-16
RAD	10,865.17	AFC IND	1616283			120	Sep-16
SECURITY	5,500.00	STERLING SECURITY	1617528			60	Sep-16
WIC	8,480.00	GE HEALTHCARE	1615162			84	Sep-16
CATH LAB	2,250.00	TZ MEDICAL	1600810			84	Sep-16
CHESHIRE U(	8,485.00	STERLING SECURITY	1615061			60	Sep-16
IT	14,596.44	DELL MARKETING	1619402			60	Sep-16
MARKETING	7,144.73	WB MASON	1615438			120	Sep-16
NVSC	5,020.00	D AND D PAINTING	1615061			60	Sep-16

NVSC	28,024.00	D AND D PAINTING	1614102	60	Sep-16
PLANT	2,527.20	DISPLAY WRIGHT	1618457	180	Sep-16
PLANT	2,545.00	H2Z DESIGN	1618458	36	Sep-16
PLANT	15,880.90	DISPLAY WRIGHT	1618662	180	Sep-16
PLANT	18,662.55	H2Z DESIGN	1618858	60	Sep-16
PLANT	9,818.00	BRAND SERVICES	1611773	120	Sep-16
PLANT	2,750.00	MCPHEE	1618701	120	Sep-16
PLANT	10,455.00	THE S CARPENTER	1618624	120	Sep-16
SECURITY	12,805.60	BLASIUS	NA	60	Sep-16
SLEEP	49,863.27	O & G IND	1618810	36	Sep-16
SLEEP	1,400.00	MOSER	1619208	36	Sep-16
SURGERY	13,500.00	HARRY GRODSKY & CO	1615004	120	Sep-16
CARD	1,362.24	GE HEALTHCARE	1616173	84	Oct-16
RAD	121,500.00	MAMMOTONE	1615447	60	Oct-16
PLANT	3,057.97	THE S CARPENTER	1620226	60	Oct-16
NVSC	9,575.00	M FRANK HIGGINS	1620228	60	Oct-16
DAYCARE	4,689.00	COMMUNITY PLAYTHING	1620270	60	Oct-16
PLANT	19,699.20	HILL ROM 17746	1616344	180	Oct-16
PLANT	3,500.00	SIEMENS 3898	1605035	60	Oct-16
IT	67,061.70	SIEMENS 3898	1612127	60	Oct-16
PLANT	2,031.00	INDUSTRIAL RIGGERS	1700378	60	Oct-16
OR	105,000.00	OLYMPUS 16331	1700259	84	Oct-16
RESP	95,513.30	DRAEGER	1614693	60	Oct-16
RESP	26,079.32	DRAEGER	1614719	60	Oct-16
DIAG	265,401.30	TOSHIBA	15209.17	84	Oct-16
PLANT	4,200.00	CLASSIC BLDRS	1700836	120	Oct-16
OR	19,989.90	KARL STORZ	1701017	84	Oct-16
SLEEP	19,940.00	MOSER PILON	NA	120	Oct-16
HEALTH INFC	6,000.00	3M HEALTH	1616620	60	Oct-16
HEALTH INFC	51,927.10	3M HEALTH	1616705	60	Oct-16
CATH LAB	(180.00)	TZ MEDICAL	1600810	84	Oct-16
IR	14,250.00	HITACHI ALOKA	1700321	60	Nov-16
OR	38,156.25	WB MASON	1608995-BL	120	Nov-16
PLANT	2,647.50	GOOD HILL	1616795	84	Nov-16
SLEEP	2,350.00	STERLING SEC	1617656	60	Nov-16
HEALTH INFC	11,645.16	3M HEALTH	1616705	60	Nov-16
CHILD DEV	4,400.00	STERLING SEC	1617874	120	Nov-16
NVSC	9,383.41	STERIS 16811	1613193	180	Nov-16
NVSC	815.00	COMNET CONN	1617660	240	Nov-16
PLANT	2,550.00	DISPLAY WRIGHT	1701804	180	Nov-16
PLANT	5,080.00	DISPLAY WRIGHT	1701803	120	Nov-16
NVSC	9,093.50	DISPLAY WRIGHT	1614233	180	Nov-16
PLANT	13,180.00	ELECTRICAL WHOLESALES	1700192	240	Nov-16
ENVIRON	182.40	HILL ROM	1616344	24	Nov-16
PLANT	75,031.00	MACRI ASSOCIATES	1613188	120	Nov-16
SLEEP	25,118.76	O AND G	1702057	120	Nov-16

SLEEP	78,461.40	O AND G	1702014	120	Nov-16
CHILD DEV	11,532.38	CORPORATE DESIGN	1701974	60	Nov-16
SURERY	310,500.00	DELAGE LANDEN FINANCIA	NA	84	Nov-16
ANES	52,570.00	EDWARDS LIFE	1701214	84	Nov-16
CVU	52,570.00	EDWARDS LIFE	1701215	84	Nov-16
NVSC	4,766.00	M FRANK HIGGINS	1620228	60	Nov-16
QUAL MNGMT	2,895.21	WB MASON	1619347	120	Nov-16
PLANT	10,750.00	LOUREIRO CONTRACTORS	1619902	300	Nov-16
PLANT	1,494.00	NAUGATUCK WINDOW & GI	1606756	120	Nov-16
PLANT	280,237.70	S CARPENTER	VARIOUS	120	Nov-16
PLANT	1,069.96	CORPORATE DESIGN	1608144	120	Nov-16
PLANT	5,028.00	GOOD HILL	1610915	120	Nov-16
PLANT	23,803.46	VULCAN SECURITY	1610516	120	Nov-16
PLANT	8,185.00	D AND D PAINTING	1608155	120	Nov-16
PLANT	10,500.00	RED THREAD	1604378	120	Nov-16
PLANT	1,932.82	PREFERRED BUILDING MAI	NA	120	Nov-16
PLANT	900.00	CONNECTICUT SIGNCRAFT	NA	60	Nov-16
PLANT	6,350.00	TPC ASSOCIATES	1609806	120	Nov-16
PLANT	6,475.00	MACK FIRE	1612267	120	Nov-16
SLEEP	1,400.00	CONNECTICUT SIGNCRAFT	NA	60	Nov-16
RESP	(1,324.81)	DRAEGER	1614693	60	Nov-16
PLANT	7,333.62	CHIANIS & ANDERSON	1703283	180	Dec-16
PLANT	4,450.00	COCCHIOLA PAYING	1620008	180	Dec-16
PHARMACY	16,028.00	NUAIRE	1616345	84	Dec-16
OR	965.00	STERIS	1502633	180	Dec-16
TRAGER	26,143.50	WB MASON	1616821	60	Dec-16
ULTRASOUNI	56,658.23	PHILIPS HEALTH	1703124	60	Dec-16
COMM	567,760.45	ATRION PROJECT	VARIOUS	120	Dec-16
OR	8,899.16	ALIMED	1703472	60	Dec-16
NVSC	6,495.00	COVIDEN	1703750	60	Dec-16
PLANT	9,100.00	MILONE	1620105	120	Dec-16
OR	26,040.00	CARDIO MED	1703743	84	Dec-16
OR	295.92	STERIS	1703058	84	Dec-16
HIS	11,645.16	3M HEALTH 18731	1616705	60	Dec-16
NUCLEAR	5,850.00	PINESTAR	1703759	84	Dec-16
OR	7,370.28	ALIMED	1703469	84	Dec-16
OR	1,860,000.00	INTUITIVE SURGICAL	1704039	84	Dec-16
CENTRAL STI	110,000.00	ADVANCED STERILIZATION	1703849	84	Dec-16
CARDIOLOGY	5,448.96	GE MEDICAL	1616173	84	Dec-16
PLANT	15,588.14	PARK WEST	1704063	120	Dec-16
CENTRAL STI	7,287.00	MEDISAFE	1703738	84	Dec-16
OR	10,750.00	WB MASON	1608995-BL	120	Dec-16
PLANT	10,688.17	O AND G	1704238	120	Dec-16
CENTRAL STI	26,580.10	CARDINAL HEALTH	1704227	120	Dec-16
IT	70,496.00	COMPUMEDICS	1703948	60	Dec-16
BIOMEDICAL	21,945.00	RYAN MEDICAL	1619073	120	Dec-16
NICU	7,125.00	MEDELA	1704567	84	Dec-16

IT	7,411.52	DELL MRKTG 18065	1704225			60	Dec-16
OR	13,990.00	KARL STORZ	1704414			120	Dec-16
NVSC	(24,287.46)	D AND D PAINTING	1614102			60	Dec-16
RAD	10,994.91	MERGE	1704457			60	Jan-17
	(479.91)	MERGE	1704457			60	Jan-17
OR	46,542.00	VOCERA	1703737			60	Jan-17
IT	38,052.03	DELL - 18065	1704231			60	Jan-17
INVENTORY	1,123.49	INTERMETRO	1703952			240	Jan-17
	112.06	INTERMETRO	1703952			240	Jan-17
IT	80.16	DELL - 18065	1704225			60	Jan-17
	2,778.16	DELL - 18065	1704225			60	Jan-17
	57,993.94	DELL - 18065	1704225			60	Jan-17
	28,841.24	DELL - 18065	1704225			60	Jan-17
PLANT	12,109.81	CHAINIS	1704879			240	Jan-17
OR	92,620.00	TRUMPF	1704988			84	Jan-17
SLEEP	1,455.00	MOSER PILON	1705376			240	Jan-17
PLANT	14,350.00	WALKER RESTORATION	1700043			240	Jan-17
PLANT	63,329.38	ENVIRONMENTAL SERVICE	1702731			120	Jan-17
LAB	2,414.88	CDW	1705569			84	Jan-17
	2,936.13	CDW	1705569			84	Jan-17
WIC	12,875.00	CHALLENGE ENG	1616364			180	Jan-17
RAD	44,900.00	MEDICAL IMAGING	1704180			120	Jan-17
PLANT	4,043.49	O AND G IND	1703278			120	Jan-17
FOOD	3,186.69	PERFORMANCE INT	1705599			120	Jan-17
MRI	6,262.80	GETINGE	1705520			120	Jan-17
PLANT	4,200.00	CLASSIC BLDRS	1700836			240	Jan-17
PLANT	10,807.00	SIMPLEX	1705425			120	Jan-17
PLANT	13,063.00	THE S CARPENTER	1703623			300	Jan-17
CVICU	5,800.00	MEDTRONIC 17359	1706312			60	Jan-17
RAD	265,401.30	TOSHIBA	1520917			60	Jan-17
OR	(19,166.00)	STERIS CORP - 16811	1502633	SCHEDULE 1	STRAIGHT	60	Jan-17
HEALTH INFC	(36,162.58)	3M HEALTH	1616705	SCHEDULE 1	STRAIGHT	60	Jan-17
OR	50,000.00	INTUITIVE SURGICAL	1704039			84	Feb-17
OR	7,333.15	WB MASON	1705901-BL			120	Feb-17
PLANT	6,565.60	WB MASON	1608995-BL			120	Feb-17
FOOD	7,838.00	PERFORMANCE INT	1705599			120	Feb-17
IT	81,007.00	SIEMENS - 20981	1615801			60	Feb-17
WMUC	12,780.33	CHIANIS & ANDERSON	12780.33			240	Feb-17
NVSC	85,000.00	ECHOSENS	1704624			84	Feb-17
OR	295.92	STERIS	1707248			84	Feb-17
ANES	123,659.00	SIEMENS - 20981	1704630			60	Feb-17
WIC	6,926.90	WB MASON	1704424			120	Feb-17
CLIN ENG	62,500.00	BAXTER	1706273			84	Feb-17
	34.00	BAXTER	1706273			84	Feb-17
WIC	29,077.00	STERLING SEC	1705797			60	Feb-17
	(5,577.00)					60	Feb-17
BARIATRICS	3,350.00	DISPLAY WRIGHT	1708051			180	Feb-17

WIC	3,500.00	DISPLAY WRIGHT	1708057			180	Feb-17
OR	9,994.95	KARL STORZ	1707452			84	Feb-17
IT	(7,451.29)	SIEMENS 3898	1612127	SCHEDULE 1	STRAIGHT	60	Feb-17
CENTRAL STI	(1,172.80)	CARDINAL HEALTH	1704227			120	Feb-17
RAD	12,085.02	MERGE	1704455			60	Mar-17
	12,085.02	MERGE	1704455			60	Mar-17
CLINICAL EN(	14,429.55	FLUKE	1706335			84	Mar-17
	(24.15)	FLUKE	1706335			84	Mar-17
SLEEP LAB	58,354.02	O AND G	1705880			120	Mar-17
SLEEP LAB	2,910.00	MOSER	1708476			120	Mar-17
SLEEP LAB	2,425.00	MOSER	1708062			120	Mar-17
PLANT	30,549.00	O AND G	1700873			120	Mar-17
	(2,000.00)	O AND G	1700873			120	Mar-17
WOUNDCARE	38,390.00	PERIMED	1705191			84	Mar-17
CENTRAL STI	16,816.50	WB MASON	1705901BL			120	Mar-17
OR	3,699.00	HAYDEN MED	1704106			84	Mar-17
FOOD	11,663.25	PERFORMANCE	1708641			60	Mar-17
IT	90,882.00	SIEMENS	160729			60	Mar-17
EMER	59,250.00	BAXTER	1706273			60	Mar-17
PLANT	12,429.54	GOODHILL	NA (MIKE)			120	Mar-17
OB4 ORTHO	4,769.08	PHILIPS	1706091			60	Mar-17
SH5 MED	2,384.54	PHILIPS	1706091			60	Mar-17
PLANT	5,198.20	VULCAN SEC	1708449			120	Mar-17
OR	9,994.95	KARL STORZ	1708952			84	Mar-17
CRITICAL CAI	7,179.29	PHILIPS	1706111			60	Mar-17
BIO MED	147,360.00	STRATASYS	1709090			60	Mar-17
CARD	22,940.00	CIVCO	1709562			10	Mar-17
WMUC	(12,727.08)	CHIANIS & ANDERSON	12780.33			240	Mar-17
	7,440,759.52						

Explanation	To be paid from
2 new Anesthesia Fabious Tiro machines	Operating cash
2 new patient monitors with easy care cuffs	Operating cash
new sterilization container w/accessories	Operating cash
new ISTAT 1 WIRELESS ANALYZER	Operating cash
new scopes and tray sterilization sterrads	Operating cash
VC- 10 VACUUM curettate system	Operating cash
new Bladder scan w/rolling cart	Operating cash
new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
SUTURE RETRIEVER ACCESSORIES	Operating cash
Sheath High flow arthroscopy & Hopkins scope	Operating cash
B3000 BLACK BADGE & BATTERIES	Operating cash
CO2 MONITOR & ACCESSORIES	Operating cash
Artic Sun 5000E Temp manage system & calibration test unit	Operating cash
20 monitors & 10 Optiplex 7040 SFF w/dual monitor stands	Operating cash
new bldg signage	Operating cash
replace condensing unit	Operating cash
HVAC duct CLEANING & SANTIZING	Operating cash
FIRE & SMOKE DAMPER	Operating cash
New Floor scrubbers (single & dual) and burnisher	Operating cash
deposit for DEHUMIDIFIER in TRAGER BASEMENT	Operating cash
depoisit for EXPANSION VALVE in TRAGER office	Operating cash
deposit for WALL COVERING in AUDITORIUM	Operating cash
AHU-1 Cooling coil replacement	Operating cash
CATH LAB # 2 RENOVATION	Operating cash
SLEEP LAB RENOVATION	Operating cash
Boardroom Project is now complete	Operating cash
4 each of 02 CS hoses & Air CS hoses 10FT Diss Hand	Operating cash
REVERSE OSMOSIS SYSTEM	Operating cash
2 Harmonyair G5 Dual Pkg Light systems	Operating cash
RECUMBENT CROSS TRAINER-the Foundation reimbursed us for this purchase	Foundation Funds
75 sterilization containers	Operating cash
TITANIUM GE MRI TOOL KIT	Operating cash
new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
CART, SINGLE TIER CORNER	Operating cash
CAMERA, CODER & STORAGE	Operating cash
VOLUSON P8	Operating cash
Board, Carbon fiber TTL ACS Radial	Operating cash
Security Alarm install	Operating cash
24 monitors & 12 Optiplex 7040 SFF w/dual monitor stands, plus software	Operating cash
MARKETING FURNITURE-chairs, credenza, tabletop, etc	Operating cash
interior painting from water damage	Operating cash

interior painting from water damage	Operating cash
Counter Fabrication	Operating cash
Prof srvs for FEASABILITY STUDY OPEN OFFICE	Operating cash
Labor & Materials for COUNTER TOPS THROUGHOUT HOSPITAL	Operating cash
Prof Srvs for AUDITORIUM RENOVATION	Operating cash
FIRE STOP Labor & Materials	Operating cash
MAIN MEGAWATT METER REPLACEMENT	Operating cash
EPOXY COATED SHOWER BASE	Operating cash
BLASIUS 2014 CHEVROLET CRUZE	Operating cash
SLEEP LAB RENOVATION	Operating cash
MEP-SLEEP LAB RENOVATION	Operating cash
RODI PIPING & INSTALL	Operating cash
SEER 1000	Operating cash
MAMMOTEST	Operating cash
EMERGENCY TEMP WALL	Operating cash
FURNISH & INSTALL CARPET & TILE	Operating cash
DAYCARE REMEDIATION	Operating cash
BRIO BEDSIDE CABINETS & OVERHEAD ART	Operating cash
AAON RTU GAS METERING	Operating cash
SYNGO DYNAMICS SYSTEM	Operating cash
REMOVE OLD HTP/ PUT NEW IN ITS PLACE	Operating cash
BRAINLAB OPTICAL	Operating cash
V500 WORKSTATIONS	Operating cash
SMART CARE MONITORING	Operating cash
AQUILLION PRIME 80	Operating cash
MOB 4TH FLOOR LOBBY	Operating cash
FLEX-X UTRETERSCOPE	Operating cash
SLEEP DESIGN MOB	Operating cash
CDIS MULTIGROUPING	Operating cash
LICENSE/ SUPPORT/ TRAINING	Operating cash
CARBON FIBER BOARD	Operating cash
TRANSDUCER CONVEX & LINEAR	Operating cash
OR ROOM REPAIRS	Operating cash
DEHUMIDIFIER INSTALL - TRAGER	Operating cash
VIDEO INTERCOM	Operating cash
SOFTWARE LICENSE FEES	Operating cash
DOOR ACCESS SYSTEM	Operating cash
HARMONY LIGHTS/ FP	Operating cash
CABLING	Operating cash
CABINET & SHELVES	Operating cash
FRAME NEW WALL	Operating cash
CABINETS	Operating cash
CIRCUIT FOR INBND/OUTBND SWITCHING	Operating cash
DISPOSABLE LINERS	Operating cash
PCKGO HEAT EXCHGE/PUMP REPLACEMENT	Operating cash
SLEEP LAB PROJECT	Operating cash

SLEEP LAB PROJECT	Operating cash
CARPET CHILD DEV	Operating cash
INTUITIVE ROBOT BUYOUT	Operating cash
EV100 CLINICAL PLTFM & SERVICE	Operating cash
EV100 CLINICAL PLTFM & SERVICE	Operating cash
FURNISH & INSTALL CARPET & TILE	Operating cash
FURNITURE	Operating cash
DOUBLE CATCH BASIN	Operating cash
911 PJT- BLOCK WINDOWS IN LAWLOR	Operating cash
911 PJT- CONSTRUCTION PROCESS	Operating cash
911 PJT- FLOORING VINYL	Operating cash
911 PJT- DUCTWORK & EXHAUST FANS INSTALL	Operating cash
911 PJT- ELECTRICAL CONTROLS	Operating cash
911 PJT- PAINTING STAIRWELLS	Operating cash
911 PJT- SECURITY WORK SPACE	Operating cash
911 PJT- STRIPPING AND WAXING FLOORS	Operating cash
911 PJT- INTERIOR SIGNS	Operating cash
911 PJT-ACCESS CONTROL SYSTEM	Operating cash
911 PJT-SPRINKLER HEADS	Operating cash
INTERIOR SIGN BRAILLE	Operating cash
V500 WORKSTATIONS	Operating cash
1320 WEST MAIN ADDITION	Operating cash
BOLLAND AT OXYGEN TANKS REMOVE & INSTALL	Operating cash
4 FT POS PRESS RECIRC COMP	Operating cash
HARMONY DUAL & SINGLE LIGHTING	Operating cash
DR TRAGER NEW FLOOR & FURNITURE	Operating cash
ULTRASOUND SPARQ	Operating cash
ATRION TELEPHONE SYSTEM	Operating cash
LIFE POLE W/LIFT & ASSIST	Operating cash
BRAVO RECEIVER/SOFTWARE/RECORDER	Operating cash
PROFESSIONAL DESIGN	Operating cash
TITAN 450 WATT ZENON LIGHT	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
CDIS TRAINNG/LICENSE	Operating cash
ATOMLAB 500 DOSE CALIB	Operating cash
ULTRAFIN LITHO STIRUP PAIR	Operating cash
IS4000 DA VINCI XI	Operating cash
STERRAD 100NX ™	Operating cash
SEER 1000	Operating cash
WEST MAIN TRANSFORMER RELOCATION	Operating cash
ROBOTIC CARRIER FOR NIGARA	Operating cash
FLOORING	Operating cash
BASE BID	Operating cash
CART W ACCESSORIES	Operating cash
PROFUSION UPGRADE	Operating cash
CADAVER LIFT CONVEYOR	Operating cash
ENTERAL SYRINGE PUMP	Operating cash

C0MPELLENT SC220 ENCLOSURE	Operating cash
POWER LED 175 LIGHT SOURCE	Operating cash
NVSC PAINTING (WATER DAMAGE)	Operating cash
HP DL380 G9 8GB RAM	Operating cash
HP DL380 G9 8GB RAM	Operating cash
LICENSE/ SOFTWARE/ SUPPORT	Operating cash
POWEREDGE R730 SERVER	Operating cash
SHELVING	Operating cash
SHELVING	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
WEST MAIN ADDITION	Operating cash
TRUSYSTEM 7000DV & ROBOTIC PKG	Operating cash
MOB SLEEP LAB RENOVATION	Operating cash
PARKING GARAGE ASSESSMENT CONDITION	Operating cash
LIGHTING UPGRADE	Operating cash
SUNQUEST PJT/ TV, DESK,ACCESS	Operating cash
SUNQUEST PJT/ TV, DESK,ACCESS	Operating cash
OR LIGHT SUPPORT SYSTEM	Operating cash
SHIMADZU PORTABLE X-RAY	Operating cash
WALLS IN SLEEP LAB	Operating cash
GAS CHARBOILER	Operating cash
WARMING CABINET #5524	Operating cash
MOB 4TH FL LOBBY NEW WALL & DOOR	Operating cash
FIRE ALARM PANEL	Operating cash
O'BRIEN PLUMBING	Operating cash
PACEMAKER EXTERNAL	Operating cash
AQUILION CT SCAN PYMT	Operating cash
MONITORS, CAMERAS, LIGHT PKG	Operating cash
LICENSE/ SUPPORT/ TRAINING	Operating cash
TABLE MOTION UPGRADE	Operating cash
FLOORING	Operating cash
FLOORING	Operating cash
GAS CHARBOILER INSTALL	Operating cash
SERVERS	Operating cash
PROFESSIONAL SERVICES WMUC	Operating cash
FIBROSCAN 502 TOUCH	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
ACUSON SC2000 MAINFRAME	Operating cash
CHAIRS, ALL STEEL TASK	Operating cash
SPECTRUM IV PUMPS	Operating cash
SPECTRUM IV PUMPS	Operating cash
ADDITIONAL CAMERAS	Operating cash
ADDITIONAL CAMERAS	Operating cash
SHELVING & CABINETS	Operating cash

BASE CABINET & COUNTERTOPS	Operating cash
URETERSCOPE FLEXIBLE	Operating cash
SYNGO DYNAMICS SYSTEM	Operating cash
CART W ACCESSORIES	Operating cash
SOFTWARE SERVICES	Operating cash
SOFTWARE SERVICES	Operating cash
INFUSION ANALYZER	Operating cash
INFUSION ANALYZER	Operating cash
APPLICATION & CERTIFICATE	Operating cash
ARCHITECTUAL/MEP	Operating cash
ARCHITECTUAL/MEP	Operating cash
TRIAGE PROJECT	Operating cash
TRIAGE PROJECT	Operating cash
PF6001 MAIN UNIT	Operating cash
FLOORING/INSTALL	Operating cash
MARTINS ARM RETRACTOR	Operating cash
ESPRESSO MACHINE	Operating cash
UPGRADE VIRTUAL SIS SERVER	Operating cash
SPECTRUM IV PUMPS	Operating cash
PIPE TESTING PJT 911	Operating cash
MONITOR DEMOSURE SIGNVS4	Operating cash
MONITOR DEMOSURE SIGNVS4	Operating cash
DEPT OF MEDICINE DOOR	Operating cash
FLEX-X URETERSCOPE	Operating cash
INTELLIVUE MULTI SERVER	Operating cash
PRINTER CONNEX 3D	Operating cash
ASTER TEE (WATER & AIR) SYSTEM	Operating cash
PROFESSIONAL SERVICES WMUC	Operating cash

Acct #	Project Name
1600-0001	CIP Holding
1600-0002	Oncology Center Project
1600-0003	MRI Project
1600-0004	Atrion Project
1600-0005	Cheshire Project
1600-0006	Northwest 911 Project
1600-0007	Cardiac Cath Lab Project
1600-0008	Naugatuck Urgent Care
1600-0009	EPIC Project
1600-0010	East Main Street Urgent Care
1600-0011	Wound Care Lobby
1600-0012	Ambulatory Pavillion
1600-0013	West Main Street Urgent Care

Project Description	Balance as of 7/31/16	Aug-Sep Additions
CIP Holding	448,951.00	(445,893.03)
Renovations to Dr Bowen's office located in the HLRCC	495,723.17	145,129.30
Renovations to new MRI area and Behavoiral Health in Emer Rm - 4 Phases to project	3,387,211.50	588,798.05
Phase I of new phone system project	529,483.69	38,021.76
New construction for a Cheshire Urgent Care Ctr and a Primary Care/Specialty Practice	411,202.86	1,173,005.58
Renovations to 2nd floor of Lawlor Bldg for 911 Call Center	342,014.94	6,475.00
Renovations for a new Cardiac Cath Lab	1,680.00	647,552.69
Construction for a new Urgent Care Ctr in Naugatuck - Project was put off until after FY2017, expenses were for Architect designs	7,377.50	3,688.75
Project to convert our systems to EPIC to be consistent with Trinity Systems	-	-
Construction for a new Urgent Care Ctr in Waterbury located near Costco	-	-
Renovations to the Wound Care Lobby	-	-
Construction of new Ambulatory Pavillion	-	-
Renovations to West Main Street Urgent Care - Additions	-	-

Balance as of 9/30/16	Oct-Mar Additions	Balance as of 3/31/17	Project Start Date	Project expected end date	Project Budget
3,057.97	1,202.03	4,260.00			
640,852.47	568,487.73	1,209,340.20	Apr-16	FY 2017	940,000
3,976,009.55	818,747.88	4,794,757.43	Sep-15	Jun-17	5,800,000
567,505.45	(567,505.45)	-	Jan-16	Nov-16	567,505
1,584,208.44	323,873.45	1,908,081.89	Mar-16	FY 2017	2,320,388
348,489.94	(348,489.94)	-	Feb-16	Nov-16	250,000
649,232.69	41,566.49	690,799.18	May-16	FY 2017	815,823
11,066.25	41,884.50	52,950.75	FY 2018	FY 2019	2,100,000
-	2,638,475.44	2,638,475.44	Oct-16	FY 2018	20,000,000
-	588,004.49	588,004.49	Jan-17	Jul-17	3,400,000
-	6,273.90	6,273.90	Mar-17	FY 2017	49,750
-	48,528.48	48,528.48	Jan-17	FY 2019	38,000,000
-	14,495.27	14,495.27	Mar-17	FY 2018	585,000

To be paid from

Operating cash
Operating cash
Operating cash, plus a 767,013 from a State grant
Operating cash

Operating cash

Operating cash
Operating cash

Operating cash

Operating cash & possible loan from Trinity

Operating cash

Operating Cash
Needs Approval
Operating Cash

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 21,111,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**19,210,000**
Bad debts	**8,642,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,682,000**
Equity transfer	**340,000**
Changes in:	
Accounts receivable--patients, net	**(28,171,000)**
Due from affiliated entities	**10,492,000**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(51,000)**
Prepaid expenses	**1,064,000**
Other assets	**(2,266,000)**
Accounts payable	**(3,539,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(6,747,000)**
Due to third party reimbursement agencies	**(1,444,000)**
Other current liabilities	**719,000**
Accrued pension and retiree health costs	**(18,003,000)**
Other long term liabilities	**800,000**
Net cash provided by operating activities	**10,819,000**
Investing activities:	
Purchases of property, plant and equipment, net	**(23,528,000)**
Decrease in assets whose use is limited	**(1,814,000)**
Decrease in investments	**14,854,000**
Net cash used in investing activities	**(10,488,000)**
Financing activities	
Principal payments on long-term debt	**(2,750,000)**
Net cash used in financing activities	**(2,750,000)**
Net decrease in cash and cash equivalents	**(2,419,000)**
Cash and cash equivalents at beginning of period	**17,282,000**
Cash and cash equivalents at end of period	**14,863,000**

TRINITY HEALTH - NEW ENGLAND, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 14,628,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**30,251,000**
Bad debts	**16,997,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,738,000**
Equity transfer	**(5,433,000)**
Changes in:	
Accounts receivable--patients, net	**(30,659,000)**
Due from affiliated entities	**(3,334,000)**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(926,000)**
Prepaid expenses	**1,178,000**
Other assets	**682,000**
Accounts payable	**(4,606,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,710,000)**
Due to third party reimbursement agencies	**251,000**
Other current liabilities	**1,488,000**
Accrued pension and retiree health costs	**(25,380,000)**
Other long term liabilities	**(17,282,000)**
Net cash used in operating activities	**(21,137,000)**
Investing activities:	
Purchases of property, plant and equipment, net	**(36,404,000)**
Decrease in assets whose use is limited	**24,823,000**
Decrease in investments	**12,909,000**
Net cash provided by investing activities	**1,328,000**
Financing activities	
Principal payments on long-term debt	**(3,040,000)**
Net cash used in financing activities	**(3,040,000)**
Net decrease in cash and cash equivalents	**(22,849,000)**
Cash and cash equivalents at beginning of period	**72,316,000**
Cash and cash equivalents at end of period	**49,467,000**

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,300
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$1,664
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$226
H.	Malpractice Insurance Cost	$650
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$219
	Total savings 10/1-3/31	$5,059

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended March 31, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health – New England, Inc. In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $30,000 for the six month period ended March 31, 2017.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million. Savings realized for the six month period ended March 31, 2017 of $114,000. Furthermore, additional insurance premium savings of $198,000 will be realized for the annual period 7/1/2017 through 6/30/2018.

There have been significant efforts to centralize support functions across Trinity Health-New England including Finance, Revenue Cycle, and Information Systems. This has resulted in reduction of costs at Johnson of $720,000 for the six months ended March 31, 2017.

In addition, Johnson has benefited from the utilization of both regional and system office Legal Services, Compliance and Audit departments. The decrease in legal fees, consulting and auditing costs associated with this transition was $615,000 for the six month period ended March 31, 2017.

Non-salary information technology costs of $308,000 were transferred to the region at the beginning of FY 2017. Other cost reductions due to regionalization were $47,000 and $43,000 in advertising and recruitment expenses. Johnson's portion of these costs are now included in the regional allocation.

The above savings are offset by a regional allocation of $639,660 for the six month period included in other operating expenses in **Attachment A.**

During the first calendar quarter of 2017, the Enfield Oncology staff transitioned to employees of Saint Francis. This transition allows both Saint Francis and Johnson to share resources across both campuses, provide enhanced compensation packages for employees and has resulted in a lower cost to Johnson through this arrangement. Annual savings associated with this staffing restructure is $137,000 and $86,000 was realized for the six month period ended March 31, 2017.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health-New England and Trinity Health in each of the areas identified above.

Interest and insurance savings related to JMMC are included in the amounts described above. There are no additional cost savings within JMMC.

Johnson transitioned to the Trinity Total Rewards program for employee compensation and benefits. Johnson provided its employees with a 2% pay increase on September 1st. Effective 1/1/2017, Johnson employees are participating in Trinity Health's defined contribution plan which provides for a core employer contribution for all employees and matching contributions funded bi-weekly for those employees who make deferrals into the plan. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Lastly, Trinity Health – New England, Inc. (TH – NE) working with Trinity Health has engaged consultants to continue to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.0 million benefit to the Connecticut hospitals within TH - NE.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. Supply chain savings Savings realized during the six month period was $75,000.

See **Attachment A** for expense savings by category. Also, refer to financial statistics noting significant improvement in financial performance since the acquisition of Johnson by TH – NE.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining Trinity Health – New England, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. Areas of clinical quality improvement have been in decreased sepsis in readmission rates, and a reduction in serious safety events were marginal.

Also, Johnson's average daily census and year to date discharges continue to remain strong and Johnson's overall financial performance has improved significantly since the affiliation.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$1,675
B.	Fringe Benefits (workers comp)	$335
C.	Contractual Labor Fees	($1,204)
D.	Medical Supplies and Pharmaceutical Cost	$75
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$30
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$114
K.	Other Operating Expense	$373
	Total savings 10/1/2016-3/31/2017	$1,398

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$85,944	$369,304	$283,360	330%
2	Short Term Investments	$1,610,228	$1,396,623	($213,605)	-13%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$9,060,046	($8,356,653)	-48%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$1,717,728	$204,255	13%
8	Prepaid Expenses	$676,712	$694,419	$17,707	3%
9	Other Current Assets	$3,525,137	$2,632,601	($892,536)	-25%
	Total Current Assets	**$24,828,193**	**$15,870,721**	**($8,957,472)**	**-36%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,180,806	($21,359)	-1%
7	Other Noncurrent Assets	$805,530	$693,519	($112,011)	-14%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$26,423,836	$5,676,661	27%
2	Less: Accumulated Depreciation	$861,533	$2,364,255	$1,502,722	174%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,059,581**	**$4,173,939**	**21%**
3	Construction in Progress	$870,370	$88,188	($782,182)	-90%
	Total Net Fixed Assets	**$20,756,012**	**$24,147,769**	**$3,391,757**	**16%**
	Total Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$3,250,101	($1,232,369)	-27%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,527,469	$37,957	2%
3	Due To Third Party Payers	$843,823	$1,538,891	$695,068	82%
4	Due To Affiliates	$23,268,975	$10,527,920	($12,741,055)	-55%
5	Current Portion of Long Term Debt	$388,912	$392,827	$3,915	1%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$531,683	$469,090	($62,593)	-12%
	Total Current Liabilities	**$32,005,375**	**$18,706,298**	**($13,299,077)**	**-42%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$22,258,008	$21,525,532	($732,476)	-3%
3	Other Long Term Debt	$0	$0	$0	0%
	Total Long Term Debt	**$22,258,008**	**$21,525,532**	**($732,476)**	**-3%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$954,733	$1,000,286	$45,553	5%
	Total Long Term Liabilities	**$23,212,741**	**$22,525,818**	**($686,923)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,084,231	$8,252,920	-134%
2	Temporarily Restricted Net Assets	$542,473	$576,468	$33,995	6%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$2,660,699**	**$8,286,915**	**-147%**
	Total Liabilities and Net Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$168,025,861	$87,365,340	($80,660,521)	-48%
2	Less: Allowances	$106,771,249	$53,863,364	($52,907,885)	-50%
3	Less: Charity Care	$160,880	$73,514	($87,366)	-54%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$61,093,732**	**$33,428,462**	**($27,665,270)**	**-45%**
5	Provision for Bad Debts	$1,977,084	$1,137,539	($839,545)	-42%
	Net Patient Service Revenue less provision for bad debts	**$59,116,648**	**$32,290,923**	**($26,825,725)**	**-45%**
6	Other Operating Revenue	$2,726,640	$634,205	($2,092,435)	-77%
7	Net Assets Released from Restrictions	$18,000	$23,149	$5,149	29%
	Total Operating Revenue	**$61,861,288**	**$32,948,277**	**($28,913,011)**	**-47%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$25,747,624	$11,734,864	($14,012,760)	-54%
2	Fringe Benefits	$6,228,877	$2,764,667	($3,464,210)	-56%
3	Physicians Fees	$5,219,086	$1,363,342	($3,855,744)	-74%
4	Supplies and Drugs	$10,205,613	$5,686,294	($4,519,319)	-44%
5	Depreciation and Amortization	$3,012,066	$1,288,094	($1,723,972)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$913,249	$420,217	($493,032)	-54%
8	Malpractice Insurance Cost	$293,627	($27,394)	($321,021)	-109%
9	Other Operating Expenses	$15,310,826	$9,319,622	($5,991,204)	-39%
	Total Operating Expenses	**$66,930,968**	**$32,549,706**	**($34,381,262)**	**-51%**
	Income/(Loss) From Operations	**($5,069,680)**	**$398,571**	**$5,468,251**	**-108%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$33,526	$0	($33,526)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($241,788)	($48,615)	$193,173	-80%
	Total Non-Operating Revenue	**($208,262)**	**($48,615)**	**$159,647**	**-77%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($5,277,942)**	**$349,956**	**$5,627,898**	**-107%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	($605,078)	$0	$605,078	-100%
	Total Other Adjustments	**($605,078)**	**$0**	**$605,078**	**-100%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expense	($5,883,020)	$349,956	$6,232,976	-106%

Johnson Memorial Hospital

	Mar 17 YTD	Sept16* YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	-7.0%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.4%	-0.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.3%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	15.5	9.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YT
Days in Net Accounts Receivables	76.9	109.4	net ar/net patient ser rev/days in yr
Average Payment Period	164.0	186.9	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	823.7%	-402.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization	89.0%	133.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.1%	7.5%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.0	(4.5)	EBIT/Interest expense
Debt Service Coverage Ratio	2.59 x	-0.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	6.1%	-11.3%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations*	$ 399	$ (3,214)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 350	$ (3,474)	Net gain(loss)
EBIDA	$ 2,107	$ (247)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,766	$ 1,696	from bs
Net Working Capital	$ (2,835)	$ (7,177)	current assets-current liabilities
Unrestricted Assets	$ 2,084	$ (6,169)	from bs

*reflects 01/16-09/30/16

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$85,944	$369,304	$283,360	330%
2	Short Term Investments	$1,610,228	$1,396,623	($213,605)	-13%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$9,060,046	($8,356,653)	-48%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$1,717,728	$204,255	13%
8	Prepaid Expenses	$676,712	$694,419	$17,707	3%
9	Other Current Assets	$3,525,137	$2,632,601	($892,536)	-25%
	Total Current Assets	**$24,828,193**	**$15,870,721**	**($8,957,472)**	**-36%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,180,806	($21,359)	-1%
7	Other Noncurrent Assets	$805,530	$693,519	($112,011)	-14%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$26,423,836	$5,676,661	27%
2	Less: Accumulated Depreciation	$861,533	$2,364,255	$1,502,722	174%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,059,581**	**$4,173,939**	**21%**
3	Construction in Progress	$870,370	$88,188	($782,182)	-90%
	Total Net Fixed Assets	**$20,756,012**	**$24,147,769**	**$3,391,757**	**16%**
	Total Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$4,482,470	$3,250,101	($1,232,369)	-27%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,527,469	$37,957	2%
3	Due To Third Party Payers	$843,823	$1,538,891	$695,068	82%
4	Due To Affiliates	$23,268,975	$10,527,920	($12,741,055)	-55%
5	Current Portion of Long Term Debt	$388,912	$392,827	$3,915	1%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$531,683	$469,090	($62,593)	-12%
	Total Current Liabilities	**$32,005,375**	**$18,706,298**	**($13,299,077)**	**-42%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$22,258,008	$21,525,532	($732,476)	-3%
3	Other Long Term Debt	$0	$0	$0	0%
	Total Long Term Debt	**$22,258,008**	**$21,525,532**	**($732,476)**	**-3%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$954,733	$1,000,286	$45,553	5%
	Total Long Term Liabilities	**$23,212,741**	**$22,525,818**	**($686,923)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,084,231	$8,252,920	-134%
2	Temporarily Restricted Net Assets	$542,473	$576,468	$33,995	6%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$2,660,699**	**$8,286,915**	**-147%**
	Total Liabilities and Net Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$168,025,861	$87,365,340	($80,660,521)	-48%
2	Less: Allowances	$106,771,249	$53,863,364	($52,907,885)	-50%
3	Less: Charity Care	$160,880	$73,514	($87,366)	-54%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$61,093,732**	**$33,428,462**	**($27,665,270)**	**-45%**
5	Provision for Bad Debts	$1,977,084	$1,137,539	($839,545)	-42%
	Net Patient Service Revenue less provision for bad debts	**$59,116,648**	**$32,290,923**	**($26,825,725)**	**-45%**
6	Other Operating Revenue	$2,726,640	$634,205	($2,092,435)	-77%
7	Net Assets Released from Restrictions	$18,000	$23,149	$5,149	29%
	Total Operating Revenue	**$61,861,288**	**$32,948,277**	**($28,913,011)**	**-47%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$25,747,624	$11,734,864	($14,012,760)	-54%
2	Fringe Benefits	$6,228,877	$2,764,667	($3,464,210)	-56%
3	Physicians Fees	$5,219,086	$1,363,342	($3,855,744)	-74%
4	Supplies and Drugs	$10,205,613	$5,686,294	($4,519,319)	-44%
5	Depreciation and Amortization	$3,012,066	$1,288,094	($1,723,972)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$913,249	$420,217	($493,032)	-54%
8	Malpractice Insurance Cost	$293,627	($27,394)	($321,021)	-109%
9	Other Operating Expenses	$15,310,826	$9,319,622	($5,991,204)	-39%
	Total Operating Expenses	**$66,930,968**	**$32,549,706**	**($34,381,262)**	**-51%**
	Income/(Loss) From Operations	**($5,069,680)**	**$398,571**	**$5,468,251**	**-108%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$33,526	$0	($33,526)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($241,788)	($48,615)	$193,173	-80%
	Total Non-Operating Revenue	**($208,262)**	**($48,615)**	**$159,647**	**-77%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($5,277,942)**	**$349,956**	**$5,627,898**	**-107%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	($605,078)	$0	$605,078	-100%
	Total Other Adjustments	**($605,078)**	**$0**	**$605,078**	**-100%**
	Excess/(Deficiency) of Revenue Over Expense	**($5,883,020)**	**$349,956**	**$6,232,976**	**-106%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

31-Mar-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
I.	**ASSETS**			
A.	**Current Assets:**			
1	Cash and Cash Equivalents	$20,572,000	$19,853,000	($719,000)
2	Short Term Investments	$23,000	$0	($23,000)
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$26,298,000	$27,705,000	$1,407,000
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0
5	Due From Affiliates	$0	$0	$0
6	Due From Third Party Payers	$0	$0	$0
7	Inventories of Supplies	$3,889,000	$4,559,000	$670,000
8	Prepaid Expenses	$2,930,000	$2,561,000	($369,000)
9	Other Current Assets	$3,114,000	$2,185,000	($929,000)
	Total Current Assets	**$56,826,000**	**$56,863,000**	**$37,000**
B.	**Noncurrent Assets Whose Use is Limited:**			
1	Held by Trustee	$15,480,000	$15,681,000	$201,000
2	Board Designated for Capital Acquisition	$0	$0	$0
3	Funds Held in Escrow	$0	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$6,000	$6,000	$0
	Total Noncurrent Assets Whose Use is Limited:	**$15,486,000**	**$15,687,000**	**$201,000**
5	Interest in Net Assets of Foundation	$5,549,000	$5,810,000	$261,000
6	Long Term Investments	$10,973,000	$11,487,000	$514,000
7	Other Noncurrent Assets	$25,740,000	$10,565,000	($15,175,000)
C.	**Net Fixed Assets:**			
1	Property, Plant and Equipment	$91,358,000	$97,843,000	$6,485,000
2	Less: Accumulated Depreciation	$2,656,000	$10,694,000	$8,038,000
	Property, Plant and Equipment, Net	**$88,702,000**	**$87,149,000**	**($1,553,000)**
3	Construction in Progress	$7,780,000	$11,956,000	$4,176,000
	Total Net Fixed Assets	**$96,482,000**	**$99,105,000**	**$2,623,000**
	Total Assets	**$211,056,000**	**$199,517,000**	**($11,539,000)**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

31-Mar-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**			
A.	**Current Liabilities:**			
1	Accounts Payable and Accrued Expenses	$15,420,000	$18,915,000	$3,495,000
2	Salaries, Wages and Payroll Taxes	$5,045,000	$4,123,000	($922,000)
3	Due To Third Party Payers	$1,262,000	$416,000	($846,000)
4	Due To Affiliates	$0	$0	$0
5	Current Portion of Long Term Debt	$89,000	$0	($89,000)
6	Current Portion of Notes Payable	$0	$0	$0
7	Other Current Liabilities	$15,913,000	$11,558,000	($4,355,000)
	Total Current Liabilities	**$37,729,000**	**$35,012,000**	**($2,717,000)**
B.	**Long Term Debt:**			
1	Bonds Payable (Net of Current Portion)	$0	$0	$0
2	Notes Payable (Net of Current Portion)	$0	$0	$0
	Total Long Term Debt	**$0**	**$0**	**$0**
3	Accrued Pension Liability	$83,306,000	$80,137,000	($3,169,000)
4	Other Long Term Liabilities	$9,341,000	$8,303,000	($1,038,000)
	Total Long Term Liabilities	**$92,647,000**	**$88,440,000**	**($4,207,000)**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0
C.	**Net Assets:**			
1	Unrestricted Net Assets or Equity	$62,162,000	$57,279,000	($4,883,000)
2	Temporarily Restricted Net Assets	$1,970,000	$2,055,000	$85,000
3	Permanently Restricted Net Assets	$16,548,000	$16,731,000	$183,000
	Total Net Assets	**$80,680,000**	**$76,065,000**	**($4,615,000)**
	Total Liabilities and Net Assets	**$211,056,000**	**$199,517,000**	**($11,539,000)**

(6)
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(6) % DIFFERENCE
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-5%

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$406,827,000	$440,801,000	$33,974,000
2	Less: Allowances	$268,852,000	$300,974,000	$32,122,000
3	Less: Charity Care	$855,000	$2,834,000	$1,979,000
4	Less: Other Deductions	$0	$0	$0
	Total Net Patient Revenue	**$137,120,000**	**$136,993,000**	**($127,000)**
5	Provision for Bad Debts	$4,961,000	$3,494,000	($1,467,000)
	Net Patient Service Revenue less provision for bad debts	**$132,159,000**	**$133,499,000**	**$1,340,000**
6	Other Operating Revenue	$5,743,000	$4,849,000	($894,000)
7	Net Assets Released from Restrictions	$0	$0	$0
	Total Operating Revenue	**$137,902,000**	**$138,348,000**	**$446,000**
B.	**Operating Expenses:**			
1	Salaries and Wages	$45,110,000	$48,444,000	$3,334,000
2	Fringe Benefits	$14,267,000	$7,923,000	($6,344,000)
3	Physicians Fees	$9,153,000	$7,176,000	($1,977,000)
4	Supplies and Drugs	$22,612,000	$23,419,000	$807,000
5	Depreciation and Amortization	$5,737,000	$8,042,000	$2,305,000
6	Bad Debts	$0	$0	$0
7	Interest Expense	$119,000	$2,000	($117,000)
8	Malpractice Insurance Cost	$2,351,000	$1,560,000	($791,000)
9	Other Operating Expenses	$25,121,000	$26,618,000	$1,497,000
	Total Operating Expenses	**$124,470,000**	**$123,184,000**	**($1,286,000)**
	Income/(Loss) From Operations	**$13,432,000**	**$15,164,000**	**$1,732,000**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$218,000	$490,000	$272,000
2	Gifts, Contributions and Donations		$0	$0
3	Other Non-Operating Gains/(Losses)	$55,000	$50,000	($5,000)
	Total Non-Operating Revenue	**$273,000**	**$540,000**	**$267,000**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$13,705,000**	**$15,704,000**	**$1,999,000**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expenses	$13,705,000	$15,704,000	$1,999,000

(6) % DIFFERENCE
8%
12%
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-16%
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15%
0%
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(6)
%
DIFFERENCE
15%

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

31-Mar-16

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
I.	**ASSETS**			
A.	**Current Assets:**			
1	Cash and Cash Equivalents	$22,818,000	$22,077,000	($741,000)
2	Short Term Investments	$23,000	$0	($23,000)
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$30,634,000	$32,040,000	$1,406,000
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$0	($3,418,000)
5	Due From Affiliates	$0	$0	$0
6	Due From Third Party Payers	$0	$0	$0
7	Inventories of Supplies	$3,889,000	$4,560,000	$671,000
8	Prepaid Expenses	$3,515,000	$2,998,000	($517,000)
9	Other Current Assets	$3,192,000	$2,200,000	($992,000)
	Total Current Assets	**$67,489,000**	**$63,875,000**	**($3,614,000)**
B.	**Noncurrent Assets Whose Use is Limited:**			
1	Held by Trustee	$15,480,000	$15,681,000	$201,000
2	Board Designated for Capital Acquisition	$0	$0	$0
3	Funds Held in Escrow	$0	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$19,537,000	$6,000	($19,531,000)
	Total Noncurrent Assets Whose Use is Limited:	**$35,017,000**	**$15,687,000**	**($19,330,000)**
5	Interest in Net Assets of Foundation	$0	$0	$0
6	Long Term Investments	$15,428,000	$16,137,000	$709,000
7	Other Noncurrent Assets	$6,263,000	$9,726,000	$3,463,000
C.	**Net Fixed Assets:**			
1	Property, Plant and Equipment	$95,973,000	$102,544,000	$6,571,000
2	Less: Accumulated Depreciation	$2,835,000	$11,477,000	$8,642,000
	Property, Plant and Equipment, Net	**$93,138,000**	**$91,067,000**	**($2,071,000)**
3	Construction in Progress	$7,873,000	$12,062,000	$4,189,000
	Total Net Fixed Assets	**$101,011,000**	**$103,129,000**	**$2,118,000**
	Total Assets	**$225,208,000**	**$208,554,000**	**($16,654,000)**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

31-Mar-16

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**			
A.	**Current Liabilities:**			
1	Accounts Payable and Accrued Expenses	$16,465,000	$19,545,000	$3,080,000
2	Salaries, Wages and Payroll Taxes	$8,160,000	$6,515,000	($1,645,000)
3	Due To Third Party Payers	$1,262,000	$416,000	($846,000)
4	Due To Affiliates	$0	$0	$0
5	Current Portion of Long Term Debt	$337,000	$228,000	($109,000)
6	Current Portion of Notes Payable	$0	$0	$0
7	Other Current Liabilities	$13,842,000	$12,603,000	($1,239,000)
	Total Current Liabilities	**$40,066,000**	**$39,307,000**	**($759,000)**
B.	**Long Term Debt:**			
1	Bonds Payable (Net of Current Portion)	$0	$0	$0
2	Notes Payable (Net of Current Portion)	$586,000	$514,000	($72,000)
	Total Long Term Debt	**$586,000**	**$514,000**	**($72,000)**
3	Accrued Pension Liability	$83,306,000	$80,137,000	($3,169,000)
4	Other Long Term Liabilities	$21,395,000	$9,203,000	($12,192,000)
	Total Long Term Liabilities	**$105,287,000**	**$89,854,000**	**($15,433,000)**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,588,000	$2,479,000	($109,000)
C.	**Net Assets:**			
1	Unrestricted Net Assets or Equity	$58,749,000	$58,128,000	($621,000)
2	Temporarily Restricted Net Assets	$1,970,000	$2,055,000	$85,000
3	Permanently Restricted Net Assets	$16,548,000	$16,731,000	$183,000
	Total Net Assets	**$77,267,000**	**$76,914,000**	**($353,000)**
	Total Liabilities and Net Assets	**$225,208,000**	**$208,554,000**	**($16,654,000)**

(6) % DIFFERENCE
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(6) % DIFFERENCE
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SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$454,966,000	$491,688,000	$36,722,000
2	Less: Allowances	$297,453,000	$330,877,000	$33,424,000
3	Less: Charity Care	$855,000	$2,834,000	$1,979,000
4	Less: Other Deductions	$0	$0	$0
	Total Net Patient Revenue	**$156,658,000**	**$157,977,000**	**$1,319,000**
5	Provision for Bad Debts	$5,798,000	$4,885,000	($913,000)
	Net Patient Service Revenue less provision for bad debts	**$150,860,000**	**$153,092,000**	**$2,232,000**
6	Other Operating Revenue	$6,156,000	$5,429,000	($727,000)
7	Net Assets Released from Restrictions	$0	$0	$0
	Total Operating Revenue	**$157,016,000**	**$158,521,000**	**$1,505,000**
B.	**Operating Expenses:**			
1	Salaries and Wages	$64,454,000	$69,508,000	$5,054,000
2	Fringe Benefits	$16,909,000	$10,886,000	($6,023,000)
3	Physicians Fees	$9,294,000	$7,401,000	($1,893,000)
4	Supplies and Drugs	$23,572,000	$24,435,000	$863,000
5	Depreciation and Amortization	$6,107,000	$8,676,000	$2,569,000
6	Bad Debts	$0	$0	$0
7	Interest Expense	$128,000	$22,000	($106,000)
8	Malpractice Insurance Cost	$3,343,000	$2,368,000	($975,000)
9	Other Operating Expenses	$29,484,000	$31,355,000	$1,871,000
	Total Operating Expenses	**$153,291,000**	**$154,651,000**	**$1,360,000**
	Income/(Loss) From Operations	**$3,725,000**	**$3,870,000**	**$145,000**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$218,000	$490,000	$272,000
2	Gifts, Contributions and Donations		$0	$0
3	Other Non-Operating Gains/(Losses)	$55,000	$50,000	($5,000)
	Total Non-Operating Revenue	**$273,000**	**$540,000**	**$267,000**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$3,998,000**	**$4,410,000**	**$412,000**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expenses	$3,998,000	$4,410,000	$412,000

(6) % DIFFERENCE
8%
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(6)
%
DIFFERENCE
10%

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$14,863,000	($2,419,000)	-14%
2	Short Term Investments	$37,626,000	$22,759,000	($14,867,000)	-40%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$84,118,000	$19,529,000	30%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$36,994,000	($10,492,000)	-22%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$8,913,000	$8,964,000	$51,000	1%
8	Prepaid Expenses	$3,861,000	$2,797,000	($1,064,000)	-28%
9	Other Current Assets	$3,498,000	$3,950,000	$452,000	13%
	Total Current Assets	**$188,768,000**	**$175,120,000**	**($13,648,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$55,311,000	$56,453,000	$1,142,000	2%
2	Board Designated for Capital Acquisition	$42,931,000	$45,721,000	$2,790,000	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$0	($2,118,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$102,174,000**	**$1,814,000**	**2%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,935,000	($2,331,000)	-18%
6	Long Term Investments	$48,717,000	$51,061,000	$2,344,000	5%
7	Other Noncurrent Assets	$7,050,000	$8,864,000	$1,814,000	26%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$428,235,000	$9,424,000	2%
2	Less: Accumulated Depreciation	$43,734,000	$62,758,000	$19,024,000	43%
	Property, Plant and Equipment, Net	**$375,077,000**	**$365,477,000**	**($9,600,000)**	**-3%**
3	Construction in Progress	$14,905,000	$28,823,000	$13,918,000	93%
	Total Net Fixed Assets	**$389,982,000**	**$394,300,000**	**$4,318,000**	**1%**
	Total Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$30,624,000	($3,539,000)	-10%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,397,000	($6,747,000)	-18%
3	Due To Third Party Payers	$8,953,000	$7,509,000	($1,444,000)	-16%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$6,690,000	($235,000)	-3%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$9,764,000	$719,000	8%
	Total Current Liabilities	**$97,230,000**	**$85,984,000**	**($11,246,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$235,217,000	($2,515,000)	-1%
	Total Long Term Debt	**$237,732,000**	**$235,217,000**	**($2,515,000)**	**-1%**
3	Accrued Pension Liability	$227,408,000	$209,405,000	($18,003,000)	-8%
4	Other Long Term Liabilities	$51,868,000	$52,668,000	$800,000	2%
	Total Long Term Liabilities	**$517,008,000**	**$497,290,000**	**($19,718,000)**	**-4%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$70,673,000	$21,451,000	44%
2	Temporarily Restricted Net Assets	$29,372,000	$32,054,000	$2,682,000	9%
3	Permanently Restricted Net Assets	$55,311,000	$56,453,000	$1,142,000	2%
	Total Net Assets	**$133,905,000**	**$159,180,000**	**$25,275,000**	**19%**
	Total Liabilities and Net Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 OCT -MAR	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,000	$1,225,669,000	($1,026,535,000)	-46%
2	Less: Allowances	$1,498,710,000	$828,362,000	($670,348,000)	-45%
3	Less: Charity Care	$8,463,000	$9,103,000	$640,000	8%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,000**	**$388,204,000**	**($356,827,000)**	**-48%**
5	Provision for Bad Debts	$14,575,000	$8,642,000	($5,933,000)	-41%
	Net Patient Service Revenue less provision for bad debts	**$730,456,000**	**$379,562,000**	**($350,894,000)**	**-48%**
6	Other Operating Revenue	$38,574,000	$18,266,000	($20,308,000)	-53%
7	Net Assets Released from Restrictions	$3,397,000	$1,993,000	($1,404,000)	-41%
	Total Operating Revenue	**$772,427,000**	**$399,821,000**	**($372,606,000)**	**-48%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$258,412,000	$122,840,000	($135,572,000)	-52%
2	Fringe Benefits	$63,421,000	$27,879,000	($35,542,000)	-56%
3	Physicians Fees	$52,062,000	$22,292,000	($29,770,000)	-57%
4	Supplies and Drugs	$115,390,000	$65,971,000	($49,419,000)	-43%
5	Depreciation and Amortization	$44,179,000	$19,210,000	($24,969,000)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$8,115,000	$4,421,000	($3,694,000)	-46%
8	Malpractice Insurance Cost	$8,753,000	$4,721,000	($4,032,000)	-46%
9	Other Operating Expenses	$211,691,000	$115,900,000	($95,791,000)	-45%
	Total Operating Expenses	**$762,023,000**	**$383,234,000**	**($378,789,000)**	**-50%**
	Income/(Loss) From Operations	**$10,404,000**	**$16,587,000**	**$6,183,000**	**59%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,882,000	$4,945,000	($1,937,000)	-28%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,960,000)	($421,000)	$4,539,000	-92%
	Total Non-Operating Revenue	**$1,922,000**	**$4,524,000**	**$2,602,000**	**135%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Principal Payments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 MARCH	AMOUNT DIFFERENCE	% DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$72,316,000	$49,467,000	($22,849,000)	-32%
2	Short Term Investments	$49,401,000	$30,955,000	($18,446,000)	-37%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$124,168,000	$137,830,000	$13,662,000	11%
4	Current Assets Whose Use is Limited for Current Liabilities	$5,754,000	$0	($5,754,000)	-100%
5	Due From Affiliates	$3,147,000	$6,481,000	$3,334,000	106%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$14,316,000	$15,242,000	$926,000	6%
8	Prepaid Expenses	$8,569,000	$7,391,000	($1,178,000)	-14%
9	Other Current Assets	$13,155,000	$13,435,000	$280,000	2%
	Total Current Assets	**$296,339,000**	**$261,476,000**	**($34,863,000)**	**-12%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$71,841,414	$73,184,000	$1,342,586	2%
2	Board Designated for Capital Acquisition	$67,971,586	$72,277,000	$4,305,414	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$24,717,000	$0	($24,717,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$164,530,000**	**$145,461,000**	**($19,069,000)**	**-12%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$52,748,000	$58,285,000	$5,537,000	10%
7	Other Noncurrent Assets	$18,518,000	$17,556,000	($962,000)	-5%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$551,097,000	$570,246,000	$19,149,000	3%
2	Less: Accumulated Depreciation	$49,168,000	$79,463,000	$30,295,000	$1
	Property, Plant and Equipment, Net	**$501,929,000**	**$490,783,000**	**($11,146,000)**	**-2%**
3	Construction in Progress	$23,674,000	$40,973,000	$17,299,000	73%
	Total Net Fixed Assets	**$525,603,000**	**$531,756,000**	**$6,153,000**	**1%**
	Total Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 MARCH	AMOUNT DIFFERENCE	% DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$68,313,000	$63,707,000	($4,606,000)	-7%
2	Salaries, Wages and Payroll Taxes	$75,613,000	$67,903,000	($7,710,000)	-10%
3	Due To Third Party Payers	$15,903,000	$16,154,000	$251,000	2%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,821,000	$7,479,000	($342,000)	-4%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$11,999,000	$13,487,000	$1,488,000	12%
	Total Current Liabilities	**$179,649,000**	**$168,730,000**	**($10,919,000)**	**-6%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$256,156,000	$253,458,000	($2,698,000)	-1%
	Total Long Term Debt	**$256,156,000**	**$253,458,000**	**($2,698,000)**	**-1%**
3	Accrued Pension Liability	$314,044,000	$288,664,000	($25,380,000)	-8%
4	Other Long Term Liabilities	$79,162,000	$61,880,000	($17,282,000)	-22%
	Total Long Term Liabilities	**$649,362,000**	**$604,002,000**	**($45,360,000)**	**-7%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$123,226,000	$132,238,000	$9,012,000	7%
2	Temporarily Restricted Net Assets	$33,642,000	$36,380,000	$2,738,000	8%
3	Permanently Restricted Net Assets	$71,859,000	$73,184,000	$1,325,000	2%
	Total Net Assets	**$228,727,000**	**$241,802,000**	**$13,075,000**	**6%**
	Total Liabilities and Net Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 OCT -MAR	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,903,594,000	$1,990,018,000	($913,576,000)	-31%
2	Less: Allowances	$1,902,814,000	$1,329,832,000	($572,982,000)	-30%
3	Less: Charity Care	$16,893,000	$14,729,000	($2,164,000)	-13%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$983,887,000**	**$645,457,000**	**($338,430,000)**	**-34%**
5	Provision for Bad Debts	$21,382,000	$16,997,000	($4,385,000)	-21%
	Net Patient Service Revenue less provision for bad debts	**$962,505,000**	**$628,460,000**	**($334,045,000)**	**-35%**
6	Other Operating Revenue	$48,990,000	$36,152,000	($12,838,000)	-26%
7	Net Assets Released from Restrictions	$7,991,000	$2,494,000	($5,497,000)	-69%
	Total Operating Revenue	**$1,019,486,000**	**$667,106,000**	**($352,380,000)**	**-35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$447,852,000	$314,233,000	($133,619,000)	-30%
2	Fringe Benefits	$94,930,000	$52,558,000	($42,372,000)	-45%
3	Physicians Fees	$33,406,000	$24,902,000	($8,504,000)	-25%
4	Supplies and Drugs	$162,109,000	$107,533,000	($54,576,000)	-34%
5	Depreciation and Amortization	$50,735,000	$30,251,000	($20,484,000)	-40%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$9,056,000	$5,047,000	($4,009,000)	-44%
8	Malpractice Insurance Cost	$12,300,000	$9,480,000	($2,820,000)	-23%
9	Other Operating Expenses	$212,471,000	$114,986,000	($97,485,000)	-46%
	Total Operating Expenses	**$1,022,859,000**	**$658,990,000**	**($363,869,000)**	**-36%**
	Income/(Loss) From Operations	**($3,373,000)**	**$8,116,000**	**$11,489,000**	**-341%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$5,917,000	$6,960,000	$1,043,000	18%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$54,901,000	($448,000)	($55,349,000)	-101%
	Total Non-Operating Revenue	**$60,818,000**	**$6,512,000**	**($54,306,000)**	**-89%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
	Total Other Adjustments	$0	$0	$0	0%
	Excess/(Deficiency) of Revenue Over Expenses	$57,445,000	$14,628,000	($42,817,000)	-75%

User, OHCA

From: Roberts, Karen
Sent: Wednesday, November 22, 2017 10:01 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: CON Order Requirements Due 11/30 - Request for Extension

---

From: Martone, Kim
Sent: Wednesday, November 22, 2017 9:59 AM
To: 'MRosadin@stfranciscare.org' <MRosadin@stfranciscare.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: CON Order Requirements Due 11/30 - Request for Extension

Happy holidays Mary Lou, your extension is approved.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Subject: CON Order Requirements Due 11/30 - Request for Extension

Good afternoon Karen,

We are requesting an extension on our filing of the requirements under the Saint Francis, Johnson and Saint Mary's CONs. We expect to file on Friday, December 8, 2017. Please let us know if this is acceptable.

Thank you and Happy Thanksgiving.

Mary Lou Rosadini
Executive Associate to Vice President, Finance
Saint Francis Hospital and Medical Center

mrosadin@stfranciscare.org
W 860-714-1066

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Hartford, CT 06105

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User, OHCA

From: Roberts, Karen
Sent: Friday, December 08, 2017 11:51 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: Docket #s 32002, 31979, 32045

From: Roberts, Karen
Sent: Friday, December 8, 2017 11:49 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: CON Order Requirements Due 12/8

Hi Claudio – I received you voicemail this morning and it is fine to send in the bulk of the compliance filing for the three merger CONs to OHCA today and then send up the final piece (capital investments/resources) as soon as available next week. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Cotto, Carmen
Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org) <MRosadin@stfranciscare.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Schneider, Jennifer (JSchneider@stfranciscare.org) <JSchneider@stfranciscare.org>; Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>; User, OHCA <OHCA@ct.gov>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

In reference to the semi-annual documents to be filed on December 8 and future filings, please provide any related data in both PDF and Excel format, as applicable. In particular, those related to capital

commitment expenditures, cost savings and quarterly financial measures. As you might already know, Excel format makes it easier to filter and analyzed the data.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
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Executive Associate to Vice President, Finance
Saint Francis Hospital and Medical Center

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User, OHCA

From: Roberts, Karen
Sent: Friday, December 08, 2017 2:07 PM
To: Capone, Claudio
Cc: Cotto, Carmen; Martone, Kim; User, OHCA; Clarke, Ormand
Subject: CON Compliance for Docket #s 31979, 32002, 32045

Hi Claudio - I've touched base with Kim Martone, Director of Operations regarding your request for a couple of additional days for filing the entire semi-annual reporting packet for CON Docket #s 31979, 32002, 32045 and we find this acceptable. Please file your material to OHCA@ct.gov. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

-----Original Message-----
From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealthOfNE.org]
Sent: Friday, December 8, 2017 1:03 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: FW: CON Order Requirements Due 12/8

Can we send you the whole packet instead of pieces?

Sent from my iPhone

On Dec 8, 2017, at 11:48 AM, Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>> wrote:

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your Password.

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Office of Health Care Access

Connecticut Department of Public Health
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Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>) <MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>>
Cc: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>; Schneider, Jennifer (JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>) <JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>) <Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>>; User, OHCA <OHCA@ct.gov<mailto:OHCA@ct.gov>>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

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Associate Health Care Analyst
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From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
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Executive Associate to Vice President, Finance Saint Francis Hospital and Medical Center
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stfranciscare.com<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.saintfranciscare.com&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=xA-pHuONh2oLjplBmRjiQQU3cgGnjNs8UYBoGfwzluc&e=> | Facebook<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.facebook.com_SaintFrancisCT_&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=eaaYCzoAs3NzdPuq0RHvYg-p6keuRto5PH0XYHXMQHs&e=> | Twitter<https://urldefense.proofpoint.com/v2/url?u=https-3A__twitter.com_SaintFrancisCT&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=gdAZ7TJcFUh0Rea7NbHF6HFSO1fiQsro9BnnLgWXeYI&e=> | Instagram<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.instagram.com_saintfrancisct&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=rZqTOwGtsYoPaQUdgNLcrbiZeXO27iyIg6s7FKiIjEM&e=> | LinkedIn<https://urldefense.proofpoint.com/v2/url?u=http-3A__bit.ly_2g16PSv&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=Z8iYz_mkpxwpKN985Dv8qjDzqyN5pkp-4XfS_k2bisY&e=>

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User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Sent: Friday, December 08, 2017 2:30 PM
To: Roberts, Karen
Cc: Cotto, Carmen; Martone, Kim; User, OHCA; Clarke, Ormand
Subject: RE: CON Compliance for Docket #s 31979, 32002, 32045

Karen...Thank you for the quick response. We will file our complete packets no later than Tuesday morning.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning
Trinity Health Of New England
Claudio.Capone@TrinityHealthOfNE.org
W 860-714-6165
C 860-276-7975
1000 Asylum Avenue, 2109A
Hartford, CT 06105
trinityhealth-ne.org | facebook | twitter | instagram

-----Original Message-----
From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Friday, December 8, 2017 2:07 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; User, OHCA <OHCA@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: [EXTERNAL] CON Compliance for Docket #s 31979, 32002, 32045

Warning: This email originated from the Internet!

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Hi Claudio - I've touched base with Kim Martone, Director of Operations regarding your request for a couple of additional days for filing the entire semi-annual reporting packet for CON Docket #s 31979, 32002, 32045 and we find this acceptable. Please file your material to OHCA@ct.gov. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

-----Original Message-----

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealthOfNE.org]
Sent: Friday, December 8, 2017 1:03 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: FW: CON Order Requirements Due 12/8

Can we send you the whole packet instead of pieces?

Sent from my iPhone

On Dec 8, 2017, at 11:48 AM, Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>> wrote:

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your Password.

_____

Hi Claudio - I received you voicemail this morning and it is fine to send in the bulk of the compliance filing for the three merger CONs to OHCA today and then send up the final piece (capital investments/resources) as soon as available next week. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov<mailto:karen.roberts@ct.gov>

<image001.jpg><image005.jpg>

From: Cotto, Carmen
Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>)
<MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>>
Cc: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>; Schneider, Jennifer
(JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>)
<JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio
(Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>)
<Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>>; User, OHCA
<OHCA@ct.gov<mailto:OHCA@ct.gov>>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

In reference to the semi-annual documents to be filed on December 8 and future filings, please provide any related data in both PDF and Excel format, as applicable. In particular, those related to capital commitment expenditures, cost savings and quarterly financial measures. As you might already know, Excel format makes it easier to filter and analyzed the data.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov<mailto:carmen.cotto@ct.gov>

www.ct.gov/dph<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.ct.gov_dph&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=GHKw6oAuDS7C_eA86IpGSs-Hl_J8v9doeKYU9MwH-MQ&e=>

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org<mailto:Claudio.Capone@TrinityHealthOfNE.org>>
Subject: CON Order Requirements Due 11/30 - Request for Extension

Good afternoon Karen,

We are requesting an extension on our filing of the requirements under the Saint Francis, Johnson and Saint Mary's CONs. We expect to file on Friday, December 8, 2017. Please let us know if this is acceptable.

Thank you and Happy Thanksgiving.

Mary Lou Rosadini
Executive Associate to Vice President, Finance Saint Francis Hospital and Medical Center
mrosadin@stfranciscare.org<mailto:mrosadin@stfranciscare.org>
W 860-714-1066
114 Woodland Street
Hartford, CT 06105
stfranciscare.com<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.saintfranciscare.com&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=xA-pHuONh2oLjplBmRjiQQU3cgGnjNs8UYBoGfwzluc&e=> | Facebook<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.facebook.com_SaintFrancisCT_&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=eaaYCzoAs3NzdPuq0RHvYg-p6keuRto5PH0XYHXMQHs&e=> | Twitter<https://urldefense.proofpoint.com/v2/url?u=https-3A__twitter.com_SaintFrancisCT&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-

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User, OHCA

From: Cotto, Carmen
Sent: Thursday, December 14, 2017 1:59 PM
To: Roberts, Karen; User, OHCA
Subject: FW: TH Of NE Combined Filing for CON Conditions
Attachments: TH - NE 12.08.2017 COMBINED CON Conditions Filing-signed.pdf; Attachment C Johnson cashflow.xls; Attachment C Report 100 150.xlsx; Attachment B CMAED.docx; Attachment D CON Stats for JMH.xlsx; Attachment A Detail of 6 month savings.xlsx; Attachment B SFH_SFCARE cashflow.xls; Attachment B SAFNS - Reports 100 150 9 30 17.xlsx; Attachment A Detail of 6 month savings 9-30-2017.xlsx; Saint Francis Stipulation 9 Final Attachments.xlsx; CON stats Sept 2017.xlsx; Attachment 1 - Saint Mary's - FA OCHA Info for Apr17-Sep17.xlsx; Report 100_150_300_350_Sept 2017.xlsx

FYI-Claudio has to use his personal email to send the documents.

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: Trinity Health – New England Transfer of Ownership CON Conditions for:

- Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-31979-CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

Dear Mrs. Roberts,

In accordance with Trinity Health Of New England's approved CONs for the transfers of ownership of Saint Francis Care, Inc,. and Saint Mary's Health Systems, Inc. to Trinity Health Corporation and Trinity Health Of New England and for the transfer of ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc. (NKA Trinity Health Of New England), attached are the responses to the conditions set forth in each of the CON decisions.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development
Enc.

Docket Number: 15-32045-CON
Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Roberts:

In accordance with Items 6, 7, 8, 9 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

7. ***Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:***
    - ***A. A list of the of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and***
    - ***B. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and***
    - ***C. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.***

   The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer.

   See Excel Attachment 1.

8. ***For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:***

   a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

   1. the major cost savings achieved for each expense category for the semi-annual period; and

   In March of 2017, Saint Mary's switched to Trinity Health's GPO. After 6 months, estimated total savings is about $1 million.

2. the effect of these cost savings on the clinical quality of care.

There has been no impact to clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/300 (statement of operations), or successor reports.

See Attachment 2.

9. ***For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016.***

   See Attachment 3 for financial indicators.

10. ***TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.***

    In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 1
see excel file that accompanied
this package

ATTACHMENT 2

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$20,572,000	$12,027,000	($8,545,000)	-42%
2	Short Term Investments	$23,000	$0	($23,000)	-100%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$26,298,000	$30,481,000	$4,183,000	16%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,889,000	$3,981,000	$92,000	2%
8	Prepaid Expenses	$2,930,000	$1,184,000	($1,746,000)	-60%
9	Other Current Assets	$3,114,000	$6,416,000	$3,302,000	106%
	Total Current Assets	**$56,826,000**	**$54,089,000**	**($2,737,000)**	**-5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$15,480,000	$16,334,000	$854,000	6%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$6,000	$6,000	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$15,486,000**	**$16,340,000**	**$854,000**	**6%**
5	Interest in Net Assets of Foundation	$5,549,000	$6,120,000	$571,000	10%
6	Long Term Investments	$10,973,000	$13,507,000	$2,534,000	23%
7	Other Noncurrent Assets	$25,740,000	$20,465,000	($5,275,000)	-20%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$91,358,000	$144,239,000	$52,881,000	58%
2	Less: Accumulated Depreciation	$2,656,000	$18,974,000	$16,318,000	614%
	Property, Plant and Equipment, Net	**$88,702,000**	**$125,265,000**	**$36,563,000**	**41%**
3	Construction in Progress	$7,780,000	$2,115,000	($5,665,000)	-73%
	Total Net Fixed Assets	**$96,482,000**	**$127,380,000**	**$30,898,000**	**32%**
	Total Assets	**$211,056,000**	**$237,901,000**	**$26,845,000**	**13%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$15,420,000	$14,094,000	($1,326,000)	-9%
2	Salaries, Wages and Payroll Taxes	$5,045,000	$6,977,000	$1,932,000	38%
3	Due To Third Party Payers	$1,262,000	$673,000	($589,000)	-47%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$89,000	$609,000	$520,000	584%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$15,913,000	$23,435,000	$7,522,000	47%
	Total Current Liabilities	**$37,729,000**	**$45,788,000**	**$8,059,000**	**21%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$0	$24,494,000	$24,494,000	0%
	Total Long Term Debt	**$0**	**$24,494,000**	**$24,494,000**	**0%**
3	Accrued Pension Liability	$83,306,000	$73,482,000	($9,824,000)	-12%
4	Other Long Term Liabilities	$9,341,000	$18,252,000	$8,911,000	95%
	Total Long Term Liabilities	**$92,647,000**	**$116,228,000**	**$23,581,000**	**25%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$62,162,000	$56,186,000	($5,976,000)	-10%
2	Temporarily Restricted Net Assets	$1,970,000	$2,315,000	$345,000	18%
3	Permanently Restricted Net Assets	$16,548,000	$17,384,000	$836,000	5%
	Total Net Assets	**$80,680,000**	**$75,885,000**	**($4,795,000)**	**-6%**
	Total Liabilities and Net Assets	**$211,056,000**	**$237,901,000**	**$26,845,000**	**13%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$817,116,000	$879,852,000	$62,736,000	8%
2	Less: Allowances	$533,069,000	$596,674,000	$63,605,000	12%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$277,097,000**	**$274,164,000**	**($2,933,000)**	**-1%**
5	Provision for Bad Debts	$6,835,000	$6,668,000	($167,000)	-2%
	Net Patient Service Revenue less provision for bad debts	**$270,262,000**	**$267,496,000**	**($2,766,000)**	**-1%**
6	Other Operating Revenue	$12,538,000	$11,803,000	($735,000)	-6%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$282,800,000**	**$279,299,000**	**($3,501,000)**	**-1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$92,109,000	$98,418,000	$6,309,000	7%
2	Fringe Benefits	$27,925,000	$16,882,000	($11,043,000)	-40%
3	Physicians Fees	$17,827,000	$14,767,000	($3,060,000)	-17%
4	Supplies and Drugs	$44,872,000	$46,827,000	$1,955,000	4%
5	Depreciation and Amortization	$12,141,000	$16,327,000	$4,186,000	34%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$197,000	$246,000	$49,000	25%
8	Malpractice Insurance Cost	$5,079,000	$3,075,000	($2,004,000)	-39%
9	Other Operating Expenses	$52,564,000	$58,433,000	$5,869,000	11%
	Total Operating Expenses	**$252,714,000**	**$254,975,000**	**$2,261,000**	**1%**
	Income/(Loss) From Operations	**$30,086,000**	**$24,324,000**	**($5,762,000)**	**-19%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$915,000	$1,123,000	$208,000	23%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$137,000	$41,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,052,000**	**$1,164,000**	**$112,000**	**11%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$31,138,000**	**$25,488,000**	**($5,650,000)**	**-18%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$31,138,000**	**$25,488,000**	**($5,650,000)**	**-18%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$22,818,000	$14,871,000	($7,947,000)	-35%
2	Short Term Investments	$23,000	$0	($23,000)	-100%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$30,634,000	$35,927,000	$5,293,000	17%
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$0	($3,418,000)	-100%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,889,000	$3,981,000	$92,000	2%
8	Prepaid Expenses	$3,515,000	$1,450,000	($2,065,000)	-59%
9	Other Current Assets	$3,192,000	$6,429,000	$3,237,000	101%
	Total Current Assets	**$67,489,000**	**$62,658,000**	**($4,831,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$15,480,000	$16,334,000	$854,000	6%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$19,537,000	$6,000	($19,531,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$35,017,000**	**$16,340,000**	**($18,677,000)**	**-53%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$15,428,000	$18,940,000	$3,512,000	23%
7	Other Noncurrent Assets	$6,263,000	$19,887,000	$13,624,000	218%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$95,973,000	$149,155,000	$53,182,000	55%
2	Less: Accumulated Depreciation	$2,835,000	$20,269,000	$17,434,000	615%
	Property, Plant and Equipment, Net	**$93,138,000**	**$128,886,000**	**$35,748,000**	**38%**
3	Construction in Progress	$7,873,000	$2,334,000	($5,539,000)	-70%
	Total Net Fixed Assets	**$101,011,000**	**$131,220,000**	**$30,209,000**	**30%**
	Total Assets	**$225,208,000**	**$249,045,000**	**$23,837,000**	**11%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$16,465,000	$15,256,000	($1,209,000)	-7%
2	Salaries, Wages and Payroll Taxes	$8,160,000	$9,774,000	$1,614,000	20%
3	Due To Third Party Payers	$1,262,000	$673,000	($589,000)	-47%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$337,000	$771,000	$434,000	129%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$13,842,000	$25,202,000	$11,360,000	82%
	Total Current Liabilities	**$40,066,000**	**$51,676,000**	**$11,610,000**	**29%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$586,000	$24,946,000	$24,360,000	4157%
	Total Long Term Debt	**$586,000**	**$24,946,000**	**$24,360,000**	**4157%**
3	Accrued Pension Liability	$83,306,000	$73,482,000	($9,824,000)	-12%
4	Other Long Term Liabilities	$21,395,000	$19,082,000	($2,313,000)	-11%
	Total Long Term Liabilities	**$105,287,000**	**$117,510,000**	**$12,223,000**	**12%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,588,000	$2,510,000	($78,000)	-3%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$58,749,000	$57,550,000	($1,199,000)	-2%
2	Temporarily Restricted Net Assets	$1,970,000	$2,414,000	$444,000	23%
3	Permanently Restricted Net Assets	$16,548,000	$17,385,000	$837,000	5%
	Total Net Assets	**$77,267,000**	**$77,349,000**	**$82,000**	**0%**
	Total Liabilities and Net Assets	**$225,208,000**	**$249,045,000**	**$23,837,000**	**11%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$916,268,000	$978,048,000	$61,780,000	7%
2	Less: Allowances	$593,367,000	$654,455,000	$61,088,000	10%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$315,951,000**	**$314,579,000**	**($1,372,000)**	**0%**
5	Provision for Bad Debts	$8,969,000	$9,041,000	$72,000	1%
	Net Patient Service Revenue less provision for bad debts	**$306,982,000**	**$305,538,000**	**($1,444,000)**	**0%**
6	Other Operating Revenue	$10,321,000	$13,807,000	$3,486,000	34%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$317,303,000**	**$319,345,000**	**$2,042,000**	**1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$132,586,000	$141,975,000	$9,389,000	7%
2	Fringe Benefits	$33,001,000	$22,785,000	($10,216,000)	-31%
3	Physicians Fees	$18,159,000	$15,701,000	($2,458,000)	-14%
4	Supplies and Drugs	$46,930,000	$48,790,000	$1,860,000	4%
5	Depreciation and Amortization	$12,879,000	$17,455,000	$4,576,000	36%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$218,000	$275,000	$57,000	26%
8	Malpractice Insurance Cost	$2,289,000	$4,415,000	$2,126,000	93%
9	Other Operating Expenses	$62,569,000	$69,004,000	$6,435,000	10%
	Total Operating Expenses	**$308,631,000**	**$320,400,000**	**$11,769,000**	**4%**
	Income/(Loss) From Operations	**$8,672,000**	**($1,055,000)**	**($9,727,000)**	**-112%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,361,000	$1,636,000	$275,000	20%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$138,000	$42,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,499,000**	**$1,678,000**	**$179,000**	**12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

ATTACHMENT 3

Saint Mary's Hospital (hospital only)	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	2.6%	10.9%	8.7%	10.6%
Non-Operating Margin	0.6%	0.1%	0.4%	0.4%
Total Margin	3.1%	11.0%	9.1%	11.0%
Bad Debt as % of Gross Revenue	1.6%	0.1%	0.8%	0.8%
B. Liquidity				
Current Ratio	1.48	1.80	1.48	1.80
Days Cash on Hand	17	32	17	32
Days in Net Accounts Receivable	42	36	42	36
Average Payment Period	46	56	46	56
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.33	0.00	0.33	0.00
Long-term Debt to Capitalization	0.25	0.00	0.25	0.00
Unrestricted Cash to Debt	0.48	231.74	0.48	231.74
Times Interest Earned Ratio	9.9	1177.1	104.71	159.03
Debt Service Coverage Ratio	31.4	138.1	53.04	125.89
Equity Financing Ratio	3.14	2.62	3.14	2.62
D. Additional Statistics				
Income from Operations	$ 588	$ 2,523	$ 24,324	$ 30,086
Revenue Over/(Under) Expense	$ 721	$ 2,537	$ 25,488	$ 31,138
EBITDA	$ 2,040	$ 3,867	$ 40,897	$ 42,424
Patient Cash Collected	$ 19,564	$ 20,601	$ 258,671	$ 259,506
Cash and Cash Equivalents	$ 12,027	$ 20,572	$ 12,027	$ 20,572
Net Working Capital	$ 8,303	$ 19,097	$ 8,303	$ 19,097
Unrestricted Assets	$ 56,185	$ 62,163	$ 56,185	$ 62,163
Credit Ratings (S&P, FITCH and Moody's)				

Saint Mary's Health System	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	-5.6%	1.2%	-0.3%	2.7%
Non-Operating Margin	0.7%	0.2%	0.5%	0.5%
Total Margin	-4.8%	1.4%	0.2%	3.2%
Bad Debt as % of Gross Revenue	1.7%	0.5%	0.9%	1.0%
B. Liquidity				
Current Ratio	1.58	2.07	1.58	2.07
Days Cash on Hand	17	28	17	28
Days in Net Accounts Receivable	43	37	43	37
Average Payment Period	44	51	44	51
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.32	0.01	0.32	0.01
Long-term Debt to Capitalization	0.24	0.01	0.24	0.01
Unrestricted Cash to Debt	0.58	24.73	0.58	24.73
Times Interest Earned Ratio	-14.2	76.9	3.27	47.59
Debt Service Coverage Ratio	1.0	62.7	21.63	64.60
Equity Financing Ratio	3.12	2.82	3.12	2.82
D. Additional Statistics				
Income from Operations	$ (1,460)	$ 311	$ (1,055)	$ 8,672
Revenue Over/(Under) Expense	$ (1,265)	$ 373	$ 623	$ 10,171
EBITDA	$ 64	$ 1,755	$ 16,674	$ 21,769
Patient Cash Collected	$ 22,724	$ 23,618	$ 296,730	$ 296,240
Cash and Cash Equivalents	$ 14,871	$ 22,818	$ 14,871	$ 22,818
Net Working Capital	$ 10,981	$ 27,421	$ 10,981	$ 27,421
Unrestricted Assets	$ 60,060	$ 61,337	$ 60,060	$ 61,337
Credit Ratings (S&P, FITCH and Moody's)				

Docket Number: 15-31979-CON
Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation
Response to Item 9 of the Settlement and Order dated 8/1/2015
Annual Report for the Capital Investment Plan due 11/30/2017

Question 1

Provide a five-year post-closing capital investment plan detailing the proposed allocation of the $275 million capital investment commitment. The submitted plan shall account for the full $275 million commitment as stated in the proposal and include the following information:

a. A list of planned capital expenditures with detailed descriptions and associated estimated costs, and

Please refer to **Attachment 2** for FY 2017 actual capital expenditures for the twelve month period ended September 30, 2017.

Attachment 3 includes the final approved capital budget (see column C) for Trinity Health Of New England Corporation, Inc. (TH Of NE) which has been approved by Trinity Health's governing body and presented to TH Of NE's finance committee. The FY 2018 budget is for the period 7/1/2017-6/30/2018.

Attachment 3 has also been updated to reflect preliminary capital budget for FYs 2019 and 2020. TH Of NE, including Saint Francis Hospital and Medical Center, have recently completed the most recent strategic plan and will be embarking on a Master Facilities Plan in CY 2018 which will further define capital priorities over the next three to five years. In addition, as strategic projects are identified, there is a process in place to facilitate the receipt of additional capital funding from Trinity Health for these priorities. One example of a strategic priority currently under review is the Ambulatory Surgery Center (ASC) in Hartford. The ASC has been included on the attached preliminary capital budget.

b. A timeframe for the rollout of the capital projects, including estimated beginning, ending and start-up/operation dates.

See **Attachment 4** for the FY 2018 individual capital projects greater than $100,000 that have been approved to proceed at Saint Francis. The remaining dollars relating to the capital budget will be allocated based on current priorities and any critical needs that arise. These amounts are summarized by category on **Attachment 3**.

As the strategic plan is finalized and the more significant capital investments are identified, TH Of NE will provide OHCA with an update for this stipulation. TH Of NE continues to believe this approach will ensure the greatest accuracy as well as meet the intent of this stipulation.

Attachment 2
Capital Expenditure Summary
FY17 Actuals - 10/1/2016-9/30/2017
Expenditures > $100,000

	Actuals FY17
Expansion/renovations of clinical facilities	
8-2 RENOVATION	1,010,293
New compounding pharmacy for Enfield Infusion center (Johnson)	561,658
Cath Lab Renovation	464,916
Major Building Renovation	304,442
Digital Rad/Fluoro Suite Renovation	183,642
Fresh tissue lab renovation	142,340
All Other	77,620
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	
Wireless telemetry monitoring system and other patient care services equipment (Auxiliary)	1,112,037
Stryker Power Equipment	962,422
Replacment of the treatment planning system; Pinncle and transition to Raytstation.	464,125
Stryker Sonopet (Qty 2) Spine and OR	301,625
OSI Spine Table	103,776
All Other	131,464
Information Technology	
IT Infrastructure to support CT hospitals	7,815,836
Hardware General, IT Refresh	1,170,494
Infrastructure Movement and Replacmement of Data Center	661,965
EMC archive to migrate data from Caremedic	197,873
EPIC-PHASE 2 (PHASE 1 CIP1253)	172,286
Software-General OB Server	172,125
All Other	190,749
Investment in facilities, medical and non-medical equipment and technology	
Replace portable X-Ray Units(2)/Replace X-Ray Rad Room	1,236,315
Bed and patient recliner replacement	1,193,940
Energy Upgrade-SFHMC, RHHCT, & JMMC	617,382
Replace Dearatoron boiler system	508,753
North Campus Roof Replacement	348,793
Replace Nurse Call Center	334,675
Window Replacement Program	243,075
Generator Emergency - Replace the 400KW Building 1 Generator	233,746
Emergency Room Stretchers and Ultrasounds	227,617
4 Heat Exchangers-Cancer Center	222,365
CardioQuip Heater Cooler	211,177
SPY Intraoperative Laser Angio	175,000
Natus Vision EEG system	151,067
HVAC - Air-conditioner - HVAC - AHU - Replace S-6 In Lower Penthouse in B-2	140,433
REPLACE COLLINS GARAGE RUSTED CONDUITS/WIRING	133,629
Philips EPIQ 7 Echo Machine	131,043
FACILITIES GEN. - RENOV-ELECT.WHOLESALERS FACILITY FOR PARKING	124,006
Medivator Washers	115,301
Purchase Cryo Console	100,000
All Other (n=95)	703,722
Physician acquisitions/ambulatory network development	
SFMG Vernon Suite 200-201	459,964

Attachment 2
Capital Expenditure Summary
FY17 Actuals - 10/1/2016-9/30/2017
Expenditures > $100,000

	Actuals FY17
Medical Office Building Renovations	392,486
ASC Project (Planning, Design and Construction)	110,542
All Other	66,347
Reallocation to Johnson Memorial - part of strategic growth of RHM	
PeopleSoft Implementation	416,167
Kronos Implementation	412,756
All Other	15,739
Saint Mary's Epic Implementation	
Epic Implementation	**21,433,313**
Capital leases associated with Epic and other	
Capital leases associated with Epic and other	**1,298,154**
Total	**47,959,194**
Johnson local capital expenditures (see Johnson Filing)	$ 2,259,103
Saint Mary's local capital expenditures (see Saint Mary's Filing)	26,210,322
Total Capital Expenditures THOFNE CT Hospitals	$ 76,428,619.18

Attachment 3

Preliminary Capital Investment Plan for Trinity Health Of New England (f/k/a Saint Francis *Care* , Inc.)

Dollars in Thousands

	<Prior Version> (a)	<Actuals> <Prior Version>	<Actuals> <New> (b)	|----------(c)(d) ----------|			
	Five Year Total	FY 2016 Expenditures (10/1/2015-9/30/2016)	FY2017 Expenditures (10/1/16- 9/30/17)	FY 2018 Budget (7/1/2017-6/30/2018)	FY 2019 Budget (7/1/2018-6/30/2019)	FY 2020 Budget (7/1/2019-6/30/2020)	Estimated Post-Close Five Year Capital Spend
Preliminary capital expenditures summary							
Investment in facilities, medical and non-medical equipment and technology	$ 184,000	$ 21,428	$ 7,152	$ 2,738	$ 15,000	$ 15,000	$ 61,318
Capital leases associated with Epic and other	4,500	1,028	1,298	-	-	-	2,326
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	5,000	3,104	3,075	100	2,000	2,000	10,279
Expansion/renovations of clinical facilities	10,000	-	2,183		10,000	5,000	17,183
Physician acquisitions/ambulatory network development	23,500	-	1,029	575	1,100	1,100	3,804
Information Technology	-	3,926	10,381	9,253	9,000	9,000	41,559
Unspecified; to be allocated based on organizional priorities each year	48,000	20,015	-	7,908	10,000	15,000	52,923
Adjustments to preliminary capital expenditure summary:							
Reallocation to Johnson Memorial - part of strategic growth of RHM		1,496	3,666	4,187	2,639	645	12,633
Reallocation to Saint Mary's-part of strategic growth of RHM [(e)]		-	21,282	9,133	12,500	12,500	55,415
Saint Mary's Epic Implementation		-	26,362	-	-	-	26,362
Hartford Ambulatory Surgery Center			-	4,333	5,981	1,596	11,910
Total estimated annual capital expenditures	**$ 275,000**	**$ 50,997**	**$ 76,428**	**$ 38,226**	**$ 68,220**	**$ 61,841**	**$ 295,712**

(a) Preliminary plan for capital commitment as noted on page 635 of CON.

(b) Capital expenditures 10/1/2016-9/30/2017 see detail at Attachment 2

(C) Approved Trinity Health Of New England FY18 routine capital budget for Saint Francis and Johnson is $11.3M and $0.873M, respectively. This amount is exclusive of $15.7M earmarked for TH Of NE IT projects, of which $9.3 is targeted for St. Francis. In addition, subject to final approval, an additional $11.9M (in total) has been earmarked for an Ambulatory Surgery Center in Hartford.

(d) Amounts continue to be preliminary based on evolving RHM strategy and expected investment necessary for Saint Francis facilities and equipment, etc. The Strategic plan was recently completed and the Master Facilities Plan has recently been approved to begin for TH OF NE.

(e) Saint Mary's 5 year commitment is through 2021 based on timing of affiliation.

Note: $20,015 in FY 2016 was investment in Johnson Memorial Hospital which closed on 1/1/2016

Attachment 4
Capital Expenditure Summary
FY18 Budget - 10/1/2017-9/30/2018
Currently Approved Expenditures > $100,000

	Approved FY18 Budget
Expansion/renovations of clinical facilities	
Psychiatry Renovation	100,000
Information Technology	
3 Par Replacement non EPIC epic	3,500,000
Ciena Fiber Swtitches	1,000,000
Epic Ambulatory Licensing Gap	953,100
St Francis wireless project (completion) pull cables and old AP's	500,000
Workday - Hartford	500,000
Replace EOL Rubbermaid Carts and Buyout of Leased Carts	425,000
3 Par expansion EPIC storage	300,000
Phones Voice Gateways SFH	300,000
Replace HP blades x 16	275,000
ExtaHop network/systems monitoring	270,000
Data Domain 7200 expansion	200,000
Epic Biometrics Refresh	196,367
Fuji Synpase Extension for JMMC Echos	154,000
JMMC Email migration to SFH	120,000
Kronos 8.0 Upgrade	108,000
Auxilio	105,350
SIP Trunking Border Element controllers etc. Wallingford/SFH	100,000
All Other	246,000
Investment in facilities, medical and non-medical equipment and technology	
Renovation - Minor < $2M, 6-2 Renovations	1,800,000
OR lights rooms 1-6	324,087
Microscope for Spine OR	253,318
OSI table	102,508
All Other (n=22)	258,766
Physician acquisitions/ambulatory network development	
MOB Renovations - Minor	500,000
All Other	75,000
Unspecified; to be allocated based on organizional priorities each year	
Not Yet Allocated	7,907,504
Hartford Ambulatory Surgery Center	
Estimated FY18 Capital Expenditures	4,333,000
Total for Saint Francis (excludes SMH and Johnson on Attachment 3)	**24,907,000**

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended September 30, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annal period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost saving opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Interest rate SWAP loss for FY 17 was $887,000. Additional interest expense savings for the six months ended September 30, 2017 was approximately $430,000 as a result of favorable interest rates.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This created an overall initial decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. Effective 7/1/2017, Saint Francis received additional annual premium reductions and the impact of this reduction was $4.4 million for Saint Francis Hospital and Medical Center. The savings for the six month period ended September 30, 2017 was approximately $1.1 million favorable compared to the first six months of the fiscal year.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans,

Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis recognized an annual benefit in pension expense of $4.2 million for the twelve month period ended September 30, 2016. For the period from April 1, 2017 through September 30, 2017, Saint Francis had additional favorability in pension expense of $3.1 million. Furthermore, Trinity and Saint Francis have developed a plan to continue to adequately fund the Saint Francis defined benefit plan consistent with the Trinity Health funding policy. For the period 10/1/2016-9/30/2017, Saint Francis made contributions to the pension plan of $27.9 million. Based on the current obligations under the plan and current funding level, Saint Francis will make contributions of $32.9 million to the plan during the period 7/1/2017-6/30/2018. Historically, Saint Francis was only able to contribute approximately $9 million to the plan annually.

In January 2017, the employees of Saint Francis were brought onto to Trinity Health benefit programs which provided several enhancements to their benefits. The most significant change is that colleagues working more than twenty hours per week are participating in a defined contribution retirement program which provides a base core contribution of 3% for everyone and a matching contribution for the first 6% of a colleague's contribution. This change resulted in over $700,000 additional contributions made to employee's plans. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Saint Francis continues with the transition to the Trinity Health Group Purchasing Organization, HPG. During the period April 1, 2017 to September 30, 2017, this effort has resulted in additional supply chain savings of approximately $760,000. Most of the current saving was achieved by reducing the cost on existing goods through the implementation of the Trinity Health National Agreements. Supply Chain integration activity will continue in FY17 and FY18. In addition, as we shift to SFHMC maintenance contracts to TH master agreements with the respective vendors, SFHMC has realized savings of $400,000 associated with leveraging Trinity Health pricing for these agreements.

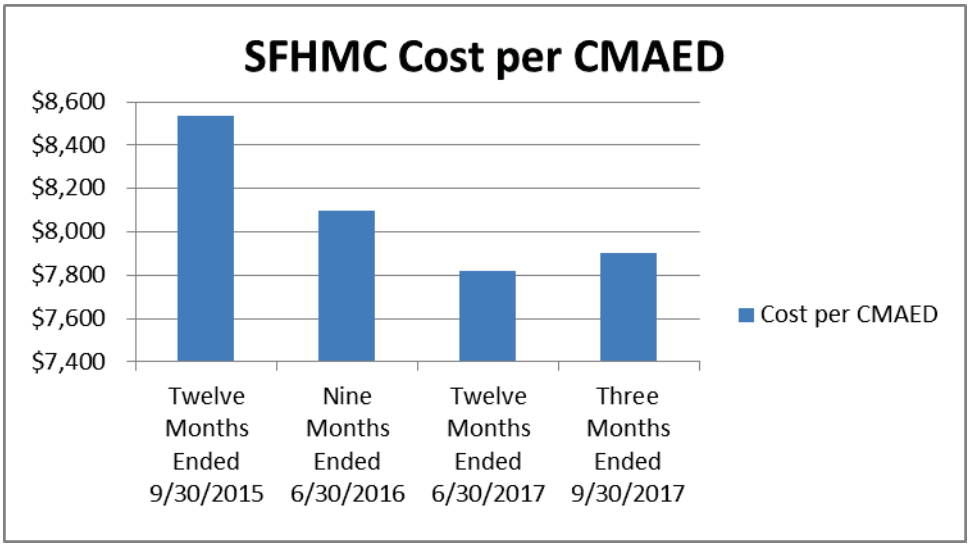
Trinity Health Of New England, Inc. (TH Of NE, formerly known as Saint Francis *Care*, Inc.), on behalf of its member hospitals including Saint Francis Hospital and Medical Center, Johnson Memorial Hospital and Saint Mary's Hospital, is currently working with Trinity Health on ensuring these hospitals continue to deliver high quality care and remain low cost providers within the community. TH-NE and Trinity Health have engaged external consultants to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.3 million benefit to the Connecticut hospitals within TH Of NE during the period 4/1/2017-9/30/2017.

Additional regionalization and alignment strategies have decreased costs in various areas including legal and external audit. Prior to 10/1/2015, Saint Francis annual audit fees were approximately $600,000. SFHMC audit fee is part of Trinity Health's audit fees and no additional expense is directly charged to the organization. Furthermore, access to legal services

at Trinity Health system office has resulted in a decrease in annual external legal fees of approximately $1.4 million.

Overall, SFHMC has seen significant decrease in costs per case mix adjusted equivalent discharge since the affiliation with Trinity Health and the establishment of the region.

Table 1: Costs per Case Mix Adjusted Equivalent Discharge



Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings. Saint Francis continues to have a strong census as well as being recognized for its clinical excellence. For example, in November 2017, Saint Francis Hospital and Medical Center has again received an "A" rating Hospital Safety Score from The Leapfrog Group, a national hospital quality watchdog organization. Saint Francis has received an "A" rating eight times since the survey's inception in 2012 and is one of only five Connecticut hospitals to receive an "A" rating this year.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The

required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$3,100
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$760
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$430
H.	Malpractice Insurance Cost	$1,100
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$400
	Total savings 10/1-3/31	$5,790

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	SEPTEMBER	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$16,067,000	($1,215,000)	-7%
2	Short Term Investments	$37,626,000	$44,486,000	$6,860,000	18%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$64,796,000	$207,000	0%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$90,696,000	$43,210,000	91%
6	Due From Third Party Payers	$5,513,000	$6,245,000	$732,000	13%
7	Inventories of Supplies	$8,913,000	$8,663,000	($250,000)	-3%
8	Prepaid Expenses	$3,861,000	$2,400,000	($1,461,000)	-38%
9	Other Current Assets	$3,498,000	$17,525,000	$14,027,000	401%
	Total Current Assets	**$188,768,000**	**$250,878,000**	**$62,110,000**	**33%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$98,242,000	$107,707,000	$9,465,000	10%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$1,783,000	($335,000)	-16%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$109,490,000**	**$9,130,000**	**9%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,197,000	($3,069,000)	-23%
6	Long Term Investments	$48,717,000	$49,364,000	$647,000	1%
7	Other Noncurrent Assets	$7,050,000	$7,050,000	$0	0%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$446,444,000	$27,633,000	7%
2	Less: Accumulated Depreciation	$43,734,000	$82,940,000	$39,206,000	90%
	Property, Plant and Equipment, Net	**$375,077,000**	**$363,504,000**	**($11,573,000)**	**-3%**
3	Construction in Progress	$14,905,000	$12,103,000	($2,802,000)	-19%
	Total Net Fixed Assets	**$389,982,000**	**$375,607,000**	**($14,375,000)**	**-4%**
	Total Assets	**$748,143,000**	**$802,586,000**	**$54,443,000**	**7%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$29,121,000	($5,042,000)	-15%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,072,000	($7,072,000)	-19%

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	SEPTEMBER	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$8,953,000	$8,727,000	($226,000)	-3%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$5,761,000	($1,164,000)	-17%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$13,365,000	$4,320,000	48%
	Total Current Liabilities	**$97,230,000**	**$88,046,000**	**($9,184,000)**	**-9%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$233,715,000	($4,017,000)	-2%
	Total Long Term Debt	**$237,732,000**	**$233,715,000**	**($4,017,000)**	**-2%**
3	Accrued Pension Liability	$227,408,000	$192,262,000	($35,146,000)	-15%
4	Other Long Term Liabilities	$51,868,000	$57,584,000	$5,716,000	11%
	Total Long Term Liabilities	**$517,008,000**	**$483,561,000**	**($33,447,000)**	**-6%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$140,435,000	$91,213,000	185%
2	Temporarily Restricted Net Assets	$29,372,000	$29,334,000	($38,000)	0%
3	Permanently Restricted Net Assets	$55,311,000	$61,210,000	$5,899,000	11%
	Total Net Assets	**$133,905,000**	**$230,979,000**	**$97,074,000**	**72%**
	Total Liabilities and Net Assets	**$748,143,000**	**$802,586,000**	**$54,443,000**	**7%**

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,496	$2,472,109,000	$219,904,504	10%
2	Less: Allowances	$1,492,769,983	$1,670,729,000	$177,959,017	12%
3	Less: Charity Care	$14,403,000	$20,662,000	$6,259,000	43%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,513**	**$780,718,000**	**$35,686,487**	**5%**
5	Provision for Bad Debts	$14,575,173	$11,262,000	($3,313,173)	-23%
	Net Patient Service Revenue less provision for bad debts	**$730,456,340**	**$769,456,000**	**$38,999,660**	**5%**
6	Other Operating Revenue	$37,241,398	$43,979,000	$6,737,602	18%
7	Net Assets Released from Restrictions	$3,396,800	$3,869,000	$472,200	14%
	Total Operating Revenue	**$771,094,538**	**$817,304,000**	**$46,209,462**	**6%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,995,100	$245,787,000	($12,208,100)	-5%
2	Fringe Benefits	$64,720,593	$52,305,000	($12,415,593)	-19%
3	Physicians Fees	$52,216,369	$48,090,000	($4,126,369)	-8%
4	Supplies and Drugs	$113,739,471	$140,126,000	$26,386,529	23%
5	Depreciation and Amortization	$43,829,465	$38,485,000	($5,344,465)	-12%
6	Bad Debts	$0		$0	0%
7	Interest Expense	$8,464,953	$9,206,000	$741,047	9%
8	Malpractice Insurance Cost	$8,752,762	$9,905,000	$1,152,238	13%
9	Other Operating Expenses	$210,971,585	$231,207,000	$20,235,415	10%
	Total Operating Expenses	**$760,690,298**	**$775,111,000**	**$14,420,702**	**2%**
	Income/(Loss) From Operations	**$10,404,240**	**$42,193,000**	**$31,788,760**	**306%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,881,703	$10,954,000	$4,072,297	59%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,959,580)	($927,000)	$4,032,580	-81%
	Total Non-Operating Revenue	**$1,922,123**	**$10,027,000**	**$8,104,877**	**422%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Principal Payments	$0	$0	$0	0%

Attachment B Cash Flow

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	$ 52,220,000	$ 12,326,000
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	38,485,000	44,179,000
Bad debts	11,262,000	14,575,000
Transfers to Trinity Health and affiliates	26,733,000	
Decrease (increase) in interest in Saint Francis Hospital and Medical Center Foundation	3,069,000	(2,287,000)
Increase in assets held in trust by others	-	(2,132,000)
Change in retirement plan related items	7,812,000	
Increase in accrued pension liability	(35,146,000)	(7,978,000)
Increase (decrease) in other long term liabilities	5,716,000	(28,861,000)
Other changes in net assets	4,409,000	(13,637,000)
Change in working capital, other than cash and cash equivalents	(75,747,000)	(62,697,000)
Net cash provided (used) in operating activities	38,813,000	(46,512,000)
Investing activities		
Purchase of property, plant and equipment, net	(24,110,000)	(34,704,000)
Purchase accounting, property, plant and equipment		55,304,000
Increase in investments	(7,507,000)	(18,597,000)
Change in permanently restricted endowment	5,900,000	
Increase in other noncurrent assets		(5,685,000)
Increase in noncurrent assets whose use is limited	(9,130,000)	(2,423,000)
Net cash used in investing activities	(34,847,000)	(6,105,000)
Financing activities		
Principal payments on long-term debt	(5,181,000)	(6,795,000)
Net cash used in financing activities	(5,181,000)	(6,795,000)
Net decrease in cash and cash equivalents	(1,215,000)	(59,412,000)
Cash and cash equivalents at beginning of period	17,282,000	76,694,000
Cash and cash equivalents at end of period	$ 16,067,000	$ 17,282,000

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	$ 0	$ 1,521,000
Accounts receivable--patients, net	(11,469,000)	(17,231,000)
Other current assets	(14,027,000)	77,000
Due from third party reimbursement agencies	(732,000)	
Inventory of supplies	250,000	789,000
Prepaid expenses	1,461,000	4,079,000
Due from affiliated entities	(43,210,000)	(42,621,000)
	(67,727,000)	(53,386,000)
Changes in current liabilities:		
Accounts payable and accrued expenses	(5,042,000)	(12,329,000)
Salary and wages, payroll taxes and amounts withheld from employees	(7,072,000)	2,146,000
Other current liabilities	4,320,000	
Due to third party reimbursement agencies	(226,000)	872,000
	(8,020,000)	(9,311,000)
Changes in working capital other than cash and cash equivalents	$ (75,747,000)	$ (62,697,000)

Attachment C Financial Indicators

Saint Francis Hospital and Medical Center

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD	Comments
A. Operating Performance:			
Operating Margin	5.2%	1.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	11.0%	8.1%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.5%	0.6%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.8	1.9	current assets/current liabilites
Days Cash on Hand	42.7	49.7	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	30.7	32.3	net ar/net patient ser rev(after bd)/days in yr
Average Payment Period	43.6	49.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	103.7%	182.7%	total debt/total equity(net assets)
Long-term Debt to Capitalization	50.3%	64.0%	LTD/LTD+net assets
Unrestricted Cash to Debt	36.0%	40.0%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	5.6	2.2	EBIT/Interest expense
Debt Service Coverage Ratio	6.0 x	4.1 x	(Net income+int+depr)/(st debt+int exp)
Equity Financing Ratio	28.8%	17.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 42,193	$ 10,404	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 52,220	$ 12,326	Net gain(loss)
EBITDA	$ 89,884	$ 62,698	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 60,553	$ 54,908	from cons bs
Net Working Capital	$ 162,832	$ 91,538	current assets-current liabilities
Unrestricted Assets	$ 140,435	$ 49,222	from cons bs

Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Item #9 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to JMMC and JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

> *a) A list of planned capital expenditures with detailed descriptions and associated estimated costs; and b) A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and c) Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by JMMC's Chief Financial Officer.*

Since the approval of the Certificate of Need, Johnson has been in the process of developing the capital budget for FY 2017 (July 1, 2016 through June 30, 2017).

For the period April 1, 2016 through September 30, 2016, Johnson incurred capital expenditures of $1.1 million (See **Attachment A**). As previously reported, Trinity Health – New England (formerly known as Saint Francis *Care,* Inc.*)* and Johnson accelerated the timing of the implementation of the Epic electronic medical record system. The total capital cost of this system implementation relating to Johnson was approximately $6.8 million, which was paid by Saint Francis Hospital and Medical Center and ultimately structured as a capital lease to Johnson. Annual capital lease payments from Johnson to Saint Francis Hospital and Medical Center total $960,000 annually for seven years, $480,000 for the six month period ended September 30, which has been included in the capital expenditure report attached.

The FY 2017-FY2020 preliminary capital budget for Johnson (see **Attachment B**) was developed as part of the Trinity Health-New England's capital and operating budget processes as well as the current strategic financial planning process for the fiscal years 2018-2020. While capital projects are inventoried and identified during the strategic planning process, the actual expenditure for FY 2017, 2018 and 2019 will likely be $1.5 million, $3.0 million and $3.0 million, respectively. Individual items on Johnson's capital request will be continuously evaluated as we are constantly assessing the strategic needs of the facilities.

Johnson Memorial Hospital/Johnson Memorial Medical Center
New Acquisition Jan - Sept 16
Stipulation # 9 Attachment A

Row Labels	Sum of ORIGINAL COST
1/1/2016	**$ 102,509**
AccuDose Door Lock	$ 50,603
MRI Portico work	$ 31,904
software	$ 13,053
(blank)	$ 6,949
2/1/2016	**$ 40,656**
HD LED CD monitor/stand/basket	$ 14,260
JSC humidity & temp control	$ 26,396
3/1/2016	**$ 43,475**
AccuDose Door Lock	$ 7,425
analog video monitor syste -icu	$ 4,987
Endo cleaning station	$ 7,312
JSC humidity & temp control	$ 4,695
pneumatic Tube system	$ 10,276
upgrad to hum/temp controls	$ 8,780
4/1/2016	**$ 55,385**
Anesthesia monitors- lease buyout	$ 12,000
Psych room renovations	$ 19,825
renov for steris washer/sink,counter	$ 11,900
Steris/Amsco Washer	$ 11,660
5/1/2016	**$ 111,352**
Centricity Perinatal Intrapartum System	$ 86,343
Cystoscope equipment	$ 25,009
6/1/2016	**$ 279,465**
EPIQ 7G Ultrasound System	$ 259,640
Psych room renovations	$ 19,825
7/1/2016	**$ 23,496**
Endo cleaning station	$ 17,061
LF-DP Tracheal Intubation Fib rscope	$ 6,435
8/1/2016	**$ 119,998**
Kawneed series alum doors	$ 7,750
PeopleSoft Licenses	$ 112,248
Grand Total	**$ 776,335**

Epic Capital Lease	$	720,000
Total Capital Expenditures including Lease 1/1-9/30	$	1,496,335
Total Capital Expenditures including Lease 4/1-9/30	$	1,069,696

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Plant Operations (8060)	Electrical upgrades - Phase One (FY18= $600k, FY19=$100k)	1		460,909	239,091		
Plant Operations (8060)	Kitchen Exhaust System	1		235,797			
Radiology (7240)	Digital Radiology room - remove old equip, install	1	R	210,000			
Nursing Admin (6010)	R Series ALC biphasic ZOLL Defibrillators (11 defibrillators)	1	R	208,611			
Plant Operations (8060)	Paving Visitor Parking Lot	2	R	126,165			
Plant Operations (8060)	Patient Room windows - recalk for blurry			50,000			
Pharmacy (7330)	Guardrails Service contract for Alaris IV pumps	1	R	72,000			
Plant Operations (8060)	Repairs to main Entrance Canopy	1		65,418			
Plant Operations (8060)	Uranium System	1		35,000			
Radiology (7240)	Raometeric - one for JSC & JMH	1	N	18,000			
Pharmacy (7330)	3-card reader controller Locks (2 Stfd, 1 Enf)	1	N	10,000			
Plant Operations (8060)	Remove & install new Fire Hydrant	1		8,100			
Pharmacy (7330)	IV room @ JMH	1	N		500,000		
Radiology (7240)	Digital Mammography upgrad 2D @ JSC and Digital @JMH	1	R		430,000		
Radiology (7240)	R&F Digital room - remove old equip, install	1	R		$369,750		
Pharmacy (7330)	AcuDose Equipment for OR suites @ JSC OR suites	1	N	-	274,001		
Radiology (7240)	GE OEC C-Arm	2	R		200,000		
Ultrasound (7280)	Ultrasound room & removal of old u/s equip	1	R		135,395		
Ultrasound (7280)	Philips EPIQ 7 Diamond Select System	1	R		118,000		
Plant Operations (8060)	Boiler,Energy Saving Controls/Hawk system	1	R		125,915		
Plant Operations (8060)	Paving Roadway, Loading Dock area, parking	2	R		$122,841		
Pharmacy (7330)	AcuDose Software Upgrade Connect	1	R		76,118		
Nursing Admin (6010)	Carefusion Alaris PCA modules, Unites, ETC02 modules	1	R		75,768		
Cardiolvascular (7250)	Cardiovascular Ultrasound Scanner	1	R		75,150		
Plant Operations (8060)	Bobcat for Snow removal & grounds work	2			$70,000		
Central Sterile Proc. (6760)	Getinge 733 sterilizer	1	N		69,636		
JSC (Surgery Ctr) (6600)	OR Surgical Lights in OR 1, 2 & 3	1	R		66,492		
Plant Operations (8060)	ABS - JMH OR/Pharmacy/Heat Exchanger	2			61,320		
Plant Operations (8060)	Lighting Protections: Main Bldg; BH; PH; & WWTP	2			$55,550		
Plant Operations (8060)	Truck	2			50,000		

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
JSC (Surgery Ctr) (6600)	Stryker Video Equipment Incl display & camera heads	2	R		40,101		
Enfield Phys Med (7093)	Mediware MediLinks OP CUL License	1	N		39,960		
Perioperative Svcs (6610)	Urology Instrumentation	1	R		34,000		
Nursing Admin (6010)	Carefusion Alaris syringe modules and software	2	R		33,252		
Nursing Admin (6010)	3 EZZ way 1000 lb ceiling lifts w continuous charge	2	N		32,262		
Plant Operations (8060)	Paint Boiler House Smoke Stack	2			$31,180		
Psychiatry (6070)	Psychiatric Safe Medical Beds - 5 beds @ $5,900	2	N		29,500		
CT Scan (7230)	ACR CT phantoms for JSC & JMH	1	N		26,000		
Plant Operations (8060)	I-Net Sysetm Upgrade	1			13,285		
Pharmacy (7330)	Camera Security System for pharm (4 Stfd, 2 Enf)	1	N		12,000		
Plant Operations (8060)	Fleet Guard Key System - control system	2			11,818		
Radiology (7240)	Stryker Stretcher - trauma - JMH	1	R		$9,100		
Plant Operations (8060)	Backup Myers Pump for Bed 6 WWTP	2			9,084		
Ultrasound (7280)	Stryker OB Stretcher for JSC	1	N		6,000		
Plant Operations (8060)	Install 9 bollards in front of Generator	1			$7,786		
	Carefusion					2,000,000	
	Pixis						
Nuclear Medicine (7300)	Siemens Symbia T6 Spect/CT camera	1	R			599,600	
CT Scan (7230)	Siemens Somatome Perspective 64 slice scanner	1	R			525,000	
Radiology (7240)	RadSpeed Auto Dr Radiographic Room	2	R			273,350	
Laboratory (7020)	Hematology replacemsnt (2) Sysmex XN2000 analyzers	2	R			173,918	
Same Day Surgury (6605)	GE patient monitors & Central station monitor	2	R			145,834	
Plant Operations (8060)	Hot Water System	3				130,000	
Laboratory (7020)	(2) ACL TOP 300 Coagulation analyzers	1	R			90,000	
Perioperative Svcs (6610)	Mammotome	1	N			$65,526	
Radiology (7240)	Bone Density (remove old equip, install)	3	R			65,000	
Central Sterile Proc. (6760)	Getinge 8668 Washer Disinfecter 12 Tray unit	3	N			55,598	
Plant Operations (8060)	Fuel duplex pump set	3				47,919	
Plant Operations (8060)	Medical Vacuum System	3				$31,997	
Respiratory Therapy (7400)	Maquet SERVO - 1 Universal Core	1	N			30,681	

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Cardiac Rehab (7590)	complete phase 3 of business plan for relocation	1	N			23,100	
Radiology (7240)	C-Arm Table	3	R			20,000	
Plant Operations (8060)	New Well Install #9 - LaFamboise	3				17,155	
Anesthesia (7370)	Glide Scope	1	R			$14,422	
CT Scan (7230)	Renovation of Ct area - stretcher, curtain, paint/floor		R			10,000	
Radiology (7240)	renovation of main xray viewing room		N			10,000	
Emergency Rm (6850)	Stryker Stretcher - Trauma/2 Big Wheel	1	N			9,405	
Post Anesthesia Care (6660	Transport Monitor	1	N	-		8,530	
Laboratory (7020)	Ortho Workstation for ID-MTS Gel Cards	1	N			7,060	
Central Sterile Proc. (6760)	Getinge Prep & Pack table	3	N			6,883	
Enfield Phys Med (7093)	NuStep Recumbent Cross Trainer w/oversized seat	2	R			6,670	
Laboratory (7020)	Hematology micro scope	1	R			$6,400	
CT Scan (7230)	Countertop Blanket Warmer		N			6,000	
Radiology (7240)	GE 9" Laser Aimer for OEC 9899 +C-Arm Part		N			6,000	
Enfield Phys Med (7093)	AC5000M Treadmill w handrails/wght cap of 550 lbs	3	R			4,972	
CT Scan (7230)	64 slice Ct Scanner with install & remove old equip,	2	R				$569,170
Plant Operations (8060)	Contingency - Emergency Repairs	3					500,000
Anesthesia (7370)	Anesthisia Machines	3	R				400,000
Plant Operations (8060)	Nirenberg - Generators	3					350,000
Grand Totals JMMC				$ 1,500,000	$ 3,450,355	$ 4,391,020	$ 1,819,170

Note: Based on current infrastructure issues at Johnson, the creation of a sewer system is expected over the next three years. The estimated costs for Johnson relating to this project is approximately $4.0 million. This amount is not included in the schedule above.

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health Of New England Corporation, Inc. (TH Of NE). In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $48,000 for the six month period ended September 30, 2017.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million. Furthermore, additional insurance premium savings of $198,000 will be realized for the annual period 7/1/2017 through 6/30/2018. For the six month period ended September 30, 2017, the additional savings realized was approximately $100,000.

There continues to be significant efforts to centralize and regionalize support functions across TH Of NE including Finance, Human Resources, Revenue Cycle, Quality, Performance Improvement, Facilities, and Information Systems. In the last twelve months, HIM and Billing have fully integrated into TH Of NE. This has resulted in reduction of costs at Johnson of $1.2 million for the six months ended September 30, 2017 for all of these support areas.

In addition, Johnson has benefited from the utilization of both regional and system office Legal Services, Compliance and Audit departments. The decrease in legal fees, consulting and auditing costs associated with this transition was $258,000 for the six month period ended September 30, 2017.

Annual non-salary information technology costs of $308,000 were transferred to the region at the beginning of FY 2017. Other cost reductions due to regionalization were $47,000 and $43,000 in advertising and recruitment expenses. Johnson's portion of these costs are now included in the regional allocation.

The above savings are offset by a TH Of NE regional allocation of $706,000 for the six month period included in other operating expenses in **Attachment A.**

Another initiative to improve quality and decrease costs that occurred during FY 2017 was the restructuring of lab services utilizing Collaborative Laboratory Services ("CLS"). This restructure transitioned the lab personnel and purchasing of supplies from Johnson to CLS. As a result, Johnson is now charged a cost per RVU for lab tests performed from CLS. This integration of Johnson's lab with CLS has resulted in net savings of $328,000 for the six month period ended September 30, 2017. Currently, we are in the process of evaluating the regionalization of the Laboratory across the entire TH Of NE region.

As previously reported, during the first calendar quarter of 2017, the Enfield Oncology staff transitioned to employees of Saint Francis. This transition allows both Saint Francis and Johnson to share resources across both campuses, provide enhanced compensation packages for employees and has resulted in a lower cost to Johnson through this arrangement. Additional savings were realized as a result of this integration and the net benefit to Johnson was $142,000 for the six months ended September 30, 2017.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health Of New England and Trinity Health in each of the areas identified above.

JMMC merged into JMH on January 23, 2017 and all savings related to this transaction were recognized in JMH prior to the merger

Lastly, TH Of NE working with Trinity Health has engaged consultants to continue to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.3 million benefit to the Connecticut hospitals within TH Of NE for the six month period.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. Supply chain savings realized during the six month period was $28,000.

See **Attachment A** for expense savings by category. Also, refer to financial statistics noting significant improvement in financial performance since the acquisition of Johnson by TH Of NE.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining TH Of NE, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. With that said, Johnson is leading the region in three critical metrics: Hospital Acquired Infections, Readmission Rates and ED Patient Experience. Areas of clinical quality improvement have also resulted in decreased serious safety events.

Also, Johnson's average daily census and year-to-date discharges continue to remain strong and Johnson's overall financial performance has improved significantly since the affiliation. See **Attachment B** which highlights the overall decrease in costs per case mix adjusted equivalent at Johnson since the acquisition on January 1, 2016.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment C.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment D** for Financial Indicators.

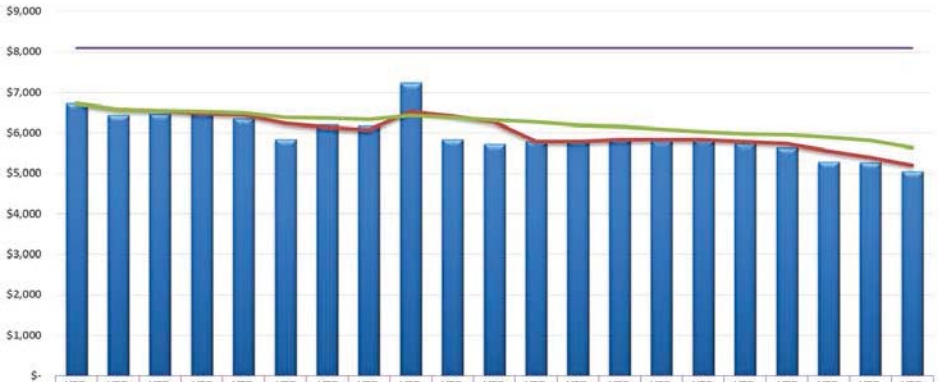
Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 4/1-9/30 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$2,140
B.	Fringe Benefits (pension and workers comp)	$428
C.	Contractual Labor Fees	($2,430)
D.	Medical Supplies and Pharmaceutical Cost	$843
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$48
H.	Malpractice Insurance Cost	$0
I.	Utilities	
J.	Business Expenses (insurance)	$101
K.	Other Operating Expense	$258
	Total savings 4/1-9/30	$1,388

Attachment B

Johnson Memorial Hospital Cost Analysis
Costs per Case Mix Adjusted Equivalent Discharge (CMAED)



	YTD Jan-16	YTD Feb-16	YTD Mar-16	YTD Apr-16	YTD May-16	YTD Jun-16	YTD Jul-16	YTD Aug-16	YTD Sept-16	YTD Oct-16	YTD Nov-16	YTD Dec-16	YTD Jan-17	YTD Feb-17	YTD Mar-17	YTD Apr-17	YTD May-17	YTD Jun-17	YTD Jul-17	YTD Aug-17	YTD Sep-17
Cost per CMAED	6,726	6,437	6,470	6,529	6,356	5,835	6,204	6,170	7,242	5,840	5,717	5,779	5,825	5,861	5,808	5,815	5,738	5,641	5,272	5,263	5,049
3 month mov average	6,726	6,582	6,545	6,479	6,452	6,240	6,132	6,070	6,539	6,418	6,266	5,779	5,773	5,822	5,831	5,828	5,787	5,731	5,551	5,392	5,195
12 month mov average	6,726	6,582	6,545	6,541	6,504	6,392	6,365	6,341	6,441	6,381	6,321	6,276	6,200	6,152	6,097	6,038	5,986	5,970	5,892	5,817	5,634
Goal	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108

Per HFM KFI YTD

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,696,172	$1,865,864	$169,692	10%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$6,738,696	($10,678,003)	-61%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$2,060,646	$547,173	36%
8	Prepaid Expenses	$676,712	$941,512	$264,800	39%
9	Other Current Assets	$3,525,137	$1,417,841	($2,107,296)	-60%
	Total Current Assets	**$24,828,193**	**$13,024,559**	**($11,803,634)**	**-48%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,000,925	($201,240)	-6%
7	Other Noncurrent Assets	$805,530	$679,961	($125,569)	-16%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$28,194,191	$7,447,016	36%
2	Less: Accumulated Depreciation	$861,533	$3,484,320	$2,622,787	304%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,709,871**	**$4,824,229**	**24%**
3	Construction in Progress	$870,370	$867,879	($2,491)	0%
	Total Net Fixed Assets	**$20,756,012**	**$25,577,750**	**$4,821,738**	**23%**
	Total Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$2,835,389	($1,647,081)	-37%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,489,870	$358	0%

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$843,823	$2,051,852	$1,208,029	143%
4	Due To Affiliates	$23,268,975	$8,077,987	($15,190,988)	-65%
5	Current Portion of Long Term Debt	$0	$0	$0	0%
6	Current Portion of Notes Payable	$992,452	$662,874	($329,578)	-33%
7	Other Current Liabilities	$531,683	$396,731	($134,952)	-25%
	Total Current Liabilities	**$32,608,915**	**$16,514,703**	**($16,094,212)**	**-49%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$21,457,110	$21,256,398	($200,712)	-1%
	Total Long Term Debt	**$21,457,110**	**$21,256,398**	**($200,712)**	**-1%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$1,152,091	$1,225,411	$73,320	6%
	Total Long Term Liabilities	**$22,609,201**	**$22,481,809**	**($127,392)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,634,070	$8,802,759	-143%
2	Temporarily Restricted Net Assets	$542,473	$652,613	$110,140	20%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$3,286,683**	**$8,912,899**	**-158%**
	Total Liabilities and Net Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	JAN - SEPT	SEPTEMBER	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$125,148,528	$175,765,124	$50,616,596	40%
2	Less: Allowances	$75,020,725	$110,810,545	$35,789,820	48%
3	Less: Charity Care	$106,845	$0	($106,845)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$50,020,958**	**$64,954,579**	**$14,933,621**	**30%**
5	Provision for Bad Debts	$2,839,922	$2,354,604	($485,318)	-17%
	Net Patient Service Revenue less provision for bad debts	**$47,181,036**	**$62,599,975**	**$15,418,939**	**33%**
6	Other Operating Revenue	$433,585	$1,794,264	$1,360,679	314%
7	Net Assets Released from Restrictions	$9,000	$23,149	$14,149	157%
	Total Operating Revenue	**$47,623,621**	**$64,417,388**	**$16,793,767**	**35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$19,306,685	$22,387,242	$3,080,557	16%
2	Fringe Benefits	$4,538,798	$4,723,464	$184,666	4%
3	Physicians Fees	$4,080,467	$5,923,698	$1,843,231	45%
4	Supplies and Drugs	$7,477,413	$10,598,733	$3,121,320	42%
5	Depreciation and Amortization	$2,385,036	$2,408,210	$23,174	1%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$646,780	$796,688	$149,908	23%
8	Malpractice Insurance Cost	$102,815	$164,120	$61,305	60%
9	Other Operating Expenses	$12,312,821	$16,792,654	$4,479,833	36%
	Total Operating Expenses	**$50,850,815**	**$63,794,809**	**$12,943,994**	**25%**
	Income/(Loss) From Operations	**($3,227,194)**	**$622,579**	**$3,849,773**	**-119%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0	$0	$0	0%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($246,748)	($25,088)	$221,660	-90%
	Total Non-Operating Revenue	**($246,748)**	**($25,088)**	**$221,660**	**-90%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($3,473,942)**	**$597,491**	**$4,071,433**	**-117%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$300,649	$300,649	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$300,649**	**$300,649**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($3,473,942)**	**$898,140**	**$4,372,082**	**-126%**
	Principal Payments	$109,419	$1,213,306	$1,103,887	1009%

Attachment C

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	September 30 2017	September 30 2016
Operating activities and non-operating income		
Excess (deficiency) of revenues over expenses	**$ 59,054**	**$ (3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**2,449,027**	**2,481,154**
Bad debts	**2,920,770**	**3,183,064**
Increase in pension and other accrued expenses	**73,320**	**801,386**
Other changes in net assets	**69,546**	**96,063**
Change in working capital, other than cash and cash equivalents	**(2,409,392)**	**2,513,860**
Net cash provided by operating activities	**3,162,325**	**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net	**(2,818,652)**	**(1,679,032)**
Decrease in long term investments	**201,240**	**269,872**
(Increase) decrease in other assets	**125,569**	**(798,396)**
Net cash used in investing activities	**(2,491,843)**	**(2,207,556)**
Financing activities		
Principal payments on long-term debt	**(530,290)**	**(819,824)**
Net cash used in financing activities	**(530,290)**	**(819,824)**
Net increase in cash and cash equivalents	**140,192**	**2,059,069**

Attachment D

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

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD*	Comments
A. Operating Performance:			
Operating Margin	1.0%	(6.8%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	5.9%	(0.4%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.6%	2.3%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	11.1	9.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	37.9	100.8	net ar/net patient ser rev/days in yr
Average Payment Period	98.2	183.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	666.8%	(399.0%)	total debt/total equity(net assets)
Long-term Debt to Capitalization	86.6%	135.5%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.5%	7.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	1.8	(4.0)	EBIT/Interest expense
Debt Service Coverage Ratio	2.62	(0.12)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	7.8%	(11.3%)	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ 623	$ (3,227)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 898	$ (3,474)	Net gain(loss)
EBIDA	$ 3,828	$ (195)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,866	$ 1,696	from bs
Net Working Capital	$ (3,490)	$ (7,781)	current assets-current liabilities
Unrestricted Assets	$ 2,634	$ (6,169)	from bs

*1/1/-9/30/16

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,696,172	$1,865,864	$169,692	10%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$6,738,696	($10,678,003)	-61%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$2,060,646	$547,173	36%
8	Prepaid Expenses	$676,712	$941,512	$264,800	39%
9	Other Current Assets	$3,525,137	$1,417,841	($2,107,296)	-60%
	Total Current Assets	**$24,828,193**	**$13,024,559**	**($11,803,634)**	**-48%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,000,925	($201,240)	-6%
7	Other Noncurrent Assets	$805,530	$679,961	($125,569)	-16%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$28,194,191	$7,447,016	36%
2	Less: Accumulated Depreciation	$861,533	$3,484,320	$2,622,787	304%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,709,871**	**$4,824,229**	**24%**
3	Construction in Progress	$870,370	$867,879	($2,491)	0%
	Total Net Fixed Assets	**$20,756,012**	**$25,577,750**	**$4,821,738**	**23%**
	Total Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$2,835,389	($1,647,081)	-37%

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,489,870	$358	0%
3	Due To Third Party Payers	$843,823	$2,051,852	$1,208,029	143%
4	Due To Affiliates	$23,268,975	$8,077,987	($15,190,988)	-65%
5	Current Portion of Long Term Debt	$0	$0	$0	0%
6	Current Portion of Notes Payable	$992,452	$662,874	($329,578)	-33%
7	Other Current Liabilities	$531,683	$396,731	($134,952)	-25%
	Total Current Liabilities	**$32,608,915**	**$16,514,703**	**($16,094,212)**	**-49%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$21,457,110	$21,256,398	($200,712)	-1%
	Total Long Term Debt	**$21,457,110**	**$21,256,398**	**($200,712)**	**-1%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$1,152,091	$1,225,411	$73,320	6%
	Total Long Term Liabilities	**$22,609,201**	**$22,481,809**	**($127,392)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,634,070	$8,802,759	-143%
2	Temporarily Restricted Net Assets	$542,473	$652,613	$110,140	20%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$3,286,683**	**$8,912,899**	**-158%**
	Total Liabilities and Net Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**

Attachment D

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

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD*	Comments
A. Operating Performance:			
Operating Margin	1.0%	(6.8%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	5.9%	(0.4%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.6%	2.3%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	11.1	9.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	37.9	100.8	net ar/net patient ser rev/days in yr
Average Payment Period	98.2	183.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	666.8%	(399.0%)	total debt/total equity(net assets)
Long-term Debt to Capitalization	86.6%	135.5%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.5%	7.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	1.8	(4.0)	EBIT/Interest expense
Debt Service Coverage Ratio	2.62	(0.12)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	7.8%	(11.3%)	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ 623	$ (3,227)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 898	$ (3,474)	Net gain(loss)
EBIDA	$ 3,828	$ (195)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,866	$ 1,696	from bs
Net Working Capital	$ (3,490)	$ (7,781)	current assets-current liabilities
Unrestricted Assets	$ 2,634	$ (6,169)	from bs

*1/1/-9/30/16

Attachment B Cash Flow

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$ 52,220,000**	**$ 12,326,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**38,485,000**	**44,179,000**
Bad debts	**11,262,000**	**14,575,000**
Transfers to Trinity Health and affiliates	**26,733,000**	
Decrease (increase) in interest in Saint Francis Hospital and Medical Center Foundation	**3,069,000**	**(2,287,000)**
Increase in assets held in trust by others	**-**	**(2,132,000)**
Change in retirement plan related items	**7,812,000**	
Increase in accrued pension liability	**(35,146,000)**	**(7,978,000)**
Increase (decrease) in other long term liabilities	**5,716,000**	**(28,861,000)**
Other changes in net assets	**4,409,000**	**(13,637,000)**
Change in working capital, other than cash and cash equivalents	**(75,747,000)**	**(62,697,000)**
Net cash provided (used) in operating activities	**38,813,000**	**(46,512,000)**
Investing activities		
Purchase of property, plant and equipment, net	**(24,110,000)**	**(34,704,000)**
Purchase accounting, property, plant and equipment		**55,304,000**
Increase in investments	**(7,507,000)**	**(18,597,000)**
Change in permanently restricted endowment	**5,900,000**	
Increase in other noncurrent assets		**(5,685,000)**
Increase in noncurrent assets whose use is limited	**(9,130,000)**	**(2,423,000)**
Net cash used in investing activities	**(34,847,000)**	**(6,105,000)**
Financing activities		
Principal payments on long-term debt	**(5,181,000)**	**(6,795,000)**
Net cash used in financing activities	**(5,181,000)**	**(6,795,000)**
Net decrease in cash and cash equivalents	**(1,215,000)**	**(59,412,000)**
Cash and cash equivalents at beginning of period	**17,282,000**	**76,694,000**
Cash and cash equivalents at end of period	**$ 16,067,000**	**$ 17,282,000**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$ 0**	**$ 1,521,000**
Accounts receivable--patients, net	**(11,469,000)**	**(17,231,000)**
Other current assets	**(14,027,000)**	**77,000**
Due from third party reimbursement agencies	**(732,000)**	
Inventory of supplies	**250,000**	**789,000**
Prepaid expenses	**1,461,000**	**4,079,000**
Due from affiliated entities	**(43,210,000)**	**(42,621,000)**
	(67,727,000)	**(53,386,000)**
Changes in current liabilities:		
Accounts payable and accrued expenses	**(5,042,000)**	**(12,329,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,072,000)**	**2,146,000**
Other current liabilities	**4,320,000**	
Due to third party reimbursement agencies	**(226,000)**	**872,000**
	(8,020,000)	**(9,311,000)**
Changes in working capital other than cash and cash equivalents	**$ (75,747,000)**	**$ (62,697,000)**

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$3,100
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$760
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$430
H.	Malpractice Insurance Cost	$1,100
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$400
	Total savings 10/1-3/31	$5,790

Saint Mary's Hospital (hospital only)	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	2.6%	10.9%	8.7%	10.6%
Non-Operating Margin	0.6%	0.1%	0.4%	0.4%
Total Margin	3.1%	11.0%	9.1%	11.0%
Bad Debt as % of Gross Revenue	1.6%	0.1%	0.8%	0.8%
B. Liquidity				
Current Ratio	1.48	1.80	1.48	1.80
Days Cash on Hand	17	32	17	32
Days in Net Accounts Receivable	42	36	42	36
Average Payment Period	46	56	46	56
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.33	0.00	0.33	0.00
Long-term Debt to Capitalization	0.25	0.00	0.25	0.00
Unrestricted Cash to Debt	0.48	231.74	0.48	231.74
Times Interest Earned Ratio	9.9	1177.1	104.71	159.03
Debt Service Coverage Ratio	31.4	138.1	53.04	125.89
Equity Financing Ratio	3.14	2.62	3.14	2.62
D. Additional Statistics				
Income from Operations	$ 588	$ 2,523	$ 24,324	$ 30,086
Revenue Over/(Under) Expense	$ 721	$ 2,537	$ 25,488	$ 31,138
EBITDA	$ 2,040	$ 3,867	$ 40,897	$ 42,424
Patient Cash Collected	$ 19,564	$ 20,601	$ 258,671	$ 259,506
Cash and Cash Equivalents	$ 12,027	$ 20,572	$ 12,027	$ 20,572
Net Working Capital	$ 8,303	$ 19,097	$ 8,303	$ 19,097
Unrestricted Assets	$ 56,185	$ 62,163	$ 56,185	$ 62,163
Credit Ratings (S&P, FITCH and Moody's)				

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$916,268,000	$978,048,000	$61,780,000	7%
2	Less: Allowances	$593,367,000	$654,455,000	$61,088,000	10%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$315,951,000**	**$314,579,000**	**($1,372,000)**	**0%**
5	Provision for Bad Debts	$8,969,000	$9,041,000	$72,000	1%
	Net Patient Service Revenue less provision for bad debts	**$306,982,000**	**$305,538,000**	**($1,444,000)**	**0%**
6	Other Operating Revenue	$10,321,000	$13,807,000	$3,486,000	34%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$317,303,000**	**$319,345,000**	**$2,042,000**	**1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$132,586,000	$141,975,000	$9,389,000	7%
2	Fringe Benefits	$33,001,000	$22,785,000	($10,216,000)	-31%
3	Physicians Fees	$18,159,000	$15,701,000	($2,458,000)	-14%
4	Supplies and Drugs	$46,930,000	$48,790,000	$1,860,000	4%
5	Depreciation and Amortization	$12,879,000	$17,455,000	$4,576,000	36%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$218,000	$275,000	$57,000	26%
8	Malpractice Insurance Cost	$2,289,000	$4,415,000	$2,126,000	93%
9	Other Operating Expenses	$62,569,000	$69,004,000	$6,435,000	10%
	Total Operating Expenses	**$308,631,000**	**$320,400,000**	**$11,769,000**	**4%**
	Income/(Loss) From Operations	**$8,672,000**	**($1,055,000)**	**($9,727,000)**	**-112%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,361,000	$1,636,000	$275,000	20%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$138,000	$42,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,499,000**	**$1,678,000**	**$179,000**	**12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

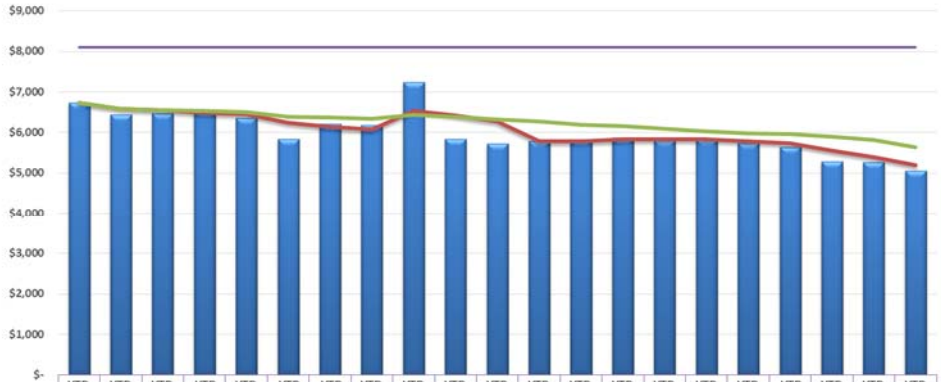
Attachment C

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	September 30 2017	September 30 2016
Operating activities and non-operating income		
Excess (deficiency) of revenues over expenses	**$ 59,054**	**$ (3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**2,449,027**	**2,481,154**
Bad debts	**2,920,770**	**3,183,064**
Increase in pension and other accrued expenses	**73,320**	**801,386**
Other changes in net assets	**69,546**	**96,063**
Change in working capital, other than cash and cash equivalents	**(2,409,392)**	**2,513,860**
Net cash provided by operating activities	**3,162,325**	**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net	**(2,818,652)**	**(1,679,032)**
Decrease in long term investments	**201,240**	**269,872**
(Increase) decrease in other assets	**125,569**	**(798,396)**
Net cash used in investing activities	**(2,491,843)**	**(2,207,556)**
Financing activities		
Principal payments on long-term debt	**(530,290)**	**(819,824)**
Net cash used in financing activities	**(530,290)**	**(819,824)**
Net increase in cash and cash equivalents	**140,192**	**2,059,069**

Attachment B

Johnson Memorial Hospital Cost Analysis
Costs per Case Mix Adjusted Equivalent Discharge (CMAED)



	YTD Jan-16	YTD Feb-16	YTD Mar-16	YTD Apr-16	YTD May-16	YTD Jun-16	YTD Jul-16	YTD Aug-16	YTD Sept-16	YTD Oct-16	YTD Nov-16	YTD Dec-16	YTD Jan-17	YTD Feb-17	YTD Mar-17	YTD Apr-17	YTD May-17	YTD Jun-17	YTD Jul-17	YTD Aug-17	YTD Sep-17
Cost per CMAED	6,726	6,437	6,470	6,529	6,356	5,835	6,204	6,170	7,242	5,840	5,717	5,779	5,825	5,861	5,808	5,815	5,738	5,641	5,272	5,263	5,049
3 month mov average	6,726	6,582	6,545	6,479	6,452	6,240	6,132	6,070	6,539	6,418	6,266	5,779	5,773	5,822	5,831	5,828	5,787	5,731	5,551	5,392	5,195
12 month mov average	6,726	6,582	6,545	6,541	6,504	6,392	6,365	6,341	6,441	6,381	6,321	6,276	6,200	6,152	6,097	6,038	5,986	5,970	5,892	5,817	5,634
Goal	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108

Per HFM KFI YTD

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 4/1-9/30 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$2,140
B.	Fringe Benefits (pension and workers comp)	$428
C.	Contractual Labor Fees	($2,430)
D.	Medical Supplies and Pharmaceutical Cost	$843
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$48
H.	Malpractice Insurance Cost	$0
I.	Utilities	
J.	Business Expenses (insurance)	$101
K.	Other Operating Expense	$258
	Total savings 4/1-9/30	$1,388

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,496	$2,472,109,000	$219,904,504	10%
2	Less: Allowances	$1,492,769,983	$1,670,729,000	$177,959,017	12%
3	Less: Charity Care	$14,403,000	$20,662,000	$6,259,000	43%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,513**	**$780,718,000**	**$35,686,487**	**5%**
5	Provision for Bad Debts	$14,575,173	$11,262,000	($3,313,173)	-23%
	Net Patient Service Revenue less provision for bad debts	**$730,456,340**	**$769,456,000**	**$38,999,660**	**5%**
6	Other Operating Revenue	$37,241,398	$43,979,000	$6,737,602	18%
7	Net Assets Released from Restrictions	$3,396,800	$3,869,000	$472,200	14%
	Total Operating Revenue	**$771,094,538**	**$817,304,000**	**$46,209,462**	**6%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,995,100	$245,787,000	($12,208,100)	-5%
2	Fringe Benefits	$64,720,593	$52,305,000	($12,415,593)	-19%
3	Physicians Fees	$52,216,369	$48,090,000	($4,126,369)	-8%
4	Supplies and Drugs	$113,739,471	$140,126,000	$26,386,529	23%
5	Depreciation and Amortization	$43,829,465	$38,485,000	($5,344,465)	-12%
6	Bad Debts	$0		$0	0%
7	Interest Expense	$8,464,953	$9,206,000	$741,047	9%
8	Malpractice Insurance Cost	$8,752,762	$9,905,000	$1,152,238	13%
9	Other Operating Expenses	$210,971,585	$231,207,000	$20,235,415	10%
	Total Operating Expenses	**$760,690,298**	**$775,111,000**	**$14,420,702**	**2%**
	Income/(Loss) From Operations	**$10,404,240**	**$42,193,000**	**$31,788,760**	**306%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,881,703	$10,954,000	$4,072,297	59%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,959,580)	($927,000)	$4,032,580	-81%
	Total Non-Operating Revenue	**$1,922,123**	**$10,027,000**	**$8,104,877**	**422%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Principal Payments	$0	$0	$0	0%

Type
Row Labels
Expansion/renovations of clinical facilities
1960 St. Franics Hospital& Medical center/Child Advo Access Control
4-2 Enhancements
5-2 CARDIOVASCULAR RENOVATION
6-2 Renovations
8-1, 8-1A ONCOLOGY RENOVATIONS
8-2 RENOVATION
95 WOODLAND-PERI-OP
A/E DESIGN REDERINGS 8-1, 8-1a & 8-2
CATH LAB RENOVATION AND REPLACEMENT
CJRI TWO O.R.s - Should be Closed to Dept# 50020 Per Rob Beeman
CWHC BUILD OUT
Digital Rad/Fluoro Suite
Furniture - Clinical Dept, Patient Family rm furniture update for 7-1/ 7-2
Gengras Dental Facility Renovations
JTO ROOM REPLACEMENTS (10 RMS)
Light Surgical
MAJOR BUILDING RENOVATION (34201)
Modify Fresh tissue lab and break room
MSH-Suisman 1st Fl - Pharmacy compounding Room
OR Floor Renovations - 6 ORs (Ambulatory)
OUTPATIENT CHF CENTER RENOVATIONS
Pharmacy upgrade
Purchase install new compounding pharmacy for Enfield Infusion center
RENOVATE 2107A , AND SUITE 1006 FOR PEDS AND OB
Small renovation of Cancer Center research lab
Waiting Room Chairs
Facility & program improvements for various service lines (e.g., CJRI, Rehab)
Auxiliary Annual Donation
Carepoint Workstations (ED)
DeMayo Knee Positioners
Midex Rex Drills(Spine Surgery
OSI Spine Table
PCS Support - Philanthropy
Radiologist/PACS/Reading Workstations
Replace Subaru Outback 2008 with 210000 miles oil leak
Replacment of the treatment planning system; Pinncle and transition to Raytstation.
Reupholster dad sleeper chairs in Labor & Delivery
Specialty Instruments-Dr. Gupta
Stryker Power Equipment
Stryker Sonopet (Qty 2) Spine and OR
Tables and Chairs
Women's Aux. Cap- May 16
Information Technology

4 laptops with docking stations
Cisco Telephones SFHMC FY2016 - 1842
EMC ARCHIVE TO MIGRATE DATA FROM CAREMEDIC
EMC PROJECT-BUILD AND ARCHIVE SFS DATA TO EMC
EPIC-PHASE 2 (PHASE 1 CIP1253)
Hardware General, IT Refresh
Infrastructure Movement and Replacmement of Data Center
Laptop PC, Oxycon Device,..
Nortel PBX Replacement
PC On wheels-Nursing 4-2
Software-General OB Server
Wi-Fi Equipment
Wireless Access Points-SFH
Workstation, Workstation on wheels

Investment in facilities, medical and non-medical equipment and technology

iViz Ultrasound System
103 WOODLAND DESIGN WORK
204 Manual Exam Table
4 Heat Exchangers-Cancer Center
ACCESS CONTROL SYSTEM-ELEVATOR AND DOOR SWIPES
Artic Sun
Beachchair Positioner
Bed Replacement
Build 4 Workstations in 4302
Building 2 Cooling Tower Repairs
Cardiac monitor units
CardioQuip Heater Cooler
CBO
Cellutome Control Unit
Chicago Stacker/Conveyer
Chiller - Re-Build of Chiller#2/#3
Collins garage parking gates
COLLINS GARAGE REPAIRS
Commercial Vacuum Stand 24"
Compressor Replacement on DAIK
Construction General - Replace OR doors - 1902
CREATE DOORWAY AND PAINT
CVOR Retractor
CWHC SHELL SPACE
Cysto Table
Digital Pathology
Dr. Grey's Office
ED Equipment
ED Equipment-Stretchers
ED Equipment-Ultrasounds
ED Stretchers
Electric Exam Table w/Stirrups

Electric Pallet Truck
Emergency replacement of main breaker on JTO Emergency Generatoir
Enclosure for MSC Loading Dock
Energy Audit-SFHMC, RHHCT, & JMMC
ESU Replacements
EXPAND EXECUTIVE OFFICES
FACILITIES GEN. - RENOV-ELECT.WHOLESALERS FACILITY FOR PARKING
FACILITIES GENERAL - RESTORE MASONRY ON BUILDINGS
FEES Camera
Follett Symphony plus ice and water dispenser
Furniture - Clinical Dept, Waiting Room Furniture L&D
Gem Premier 4000 pH/Blood Gas System
Generator Emergency - Replace the 400KW Building 1 Generator
GENGRAS 5TH FLOOR RENOVATIONS
HVAC - Air-conditioner - HVAC - AHU - Replace S-6 In Lower Penthouse in B-2
HVAC - Air-conditioner - Isolation Rooms Upgrade for PCT
HVAC-6N ADRC ADMIN. HVAC
Improvements and furniture for Suite 2107A
Install door and wall protection at CAPS
Install Second PCT Patient Toilet Grab Bars
KITCHEN ELEVATOR OVERHAUL
Light Exterior - Signage Lighting and Pole for Davita entrance
Lost ultdev01/us.s VAC Ultra T
Medical Equipment General - Foot Sets
Medivator Washers
Miscellaneous General - Trinity Signage
Monitor System - 3-5 Physio Monitor Replacement (16 pt)
Monitor System - Endoscopy - Anesthesiology Physio Monitoring EPIC Connectivity
Monitor System - Radiology Nursing Physio Monitor Replacement
Natus Vision EEG system
O2 blenders for NICU
Olympus Scope
Omni beds
Optimization & Load Demand Management
OR Tables (Skytron)
Other - Genesis Rigid Containers
Pacemaker - Replace Obsolete External Pacemakers
Pain Clinic Monitors
Perfusion Data Management System
Philips EPIQ 7 Echo Machine
Philips Transport Monitors
Plastic Hand Sets
Prevac Sterilizer Upgrade
Purchase Cryo Console
Purchase LifePak
Ready Dock Machine to Disinfect Mobile Devices
Recliners

RENOVATE 1-4 TO INCLUDE BED REPAIR ROOM & EMERGENCY OPEN CNTR
renovate suite 3206A for new compliance office
REPAIR OIL PIPING ON FUEL TANK AT SF CAMPUS
Repair/Replace Steam Traps-MSCMP
Repair/Replace Steam Traps-SFCMP
Replace Broken Ice Machine
REPLACE COLLINS GARAGE RUSTED CONDUITS/WIRING
Replace Dearatoron boiler system
Replace Nurse Call Center (AM2016-015)
REPLACE OBSOLETE PANELS
Replace portable X-Ray Units(2)/Replace X-Ray Rad Room
Replace two rotted and leaking water lines
Replacement - Ice & Water Dispenser
ROOF - REPLACEMENT OF FAILING ROOFS AT NORTH CAMPUS
Roofing-Gengras Building FY2017
SERVICE SWITCHGEARS IN BUILDING 1 AND 95 WOODLAND
Smith & Nephew Beach Chair positioner
SOLAR PANEL INSTALLATION
SPY Intraoperative Laser Angio
Surgery - Large Plastic Sets
System EP Navigation - Bard PRO EP Recording System Upgrade Windows 7
System Fire Detection - Siemens Fire Alarm Panel Replacement - 606
System Vacuum - Replace med gas and vacuum system components
Total Hip General Instrument Sets x 4
Trigger attachment replacement for Linvatech power drill
Trophon Machine
Ultrasound IV Guide Machine
Ultrasound Machine w/Probes
Urology Laser
Urology Scopes (2)
Verathon Glidescope
Vest System
water/ice machines
Window Replacement Project
WINDOWS REPLACEMENT PROGRAM LAST PHASE B5 AND B6-110

Physician acquisitions/ambulatory network development

ASC PROJECT (PLANNING, DESIGN & CONSTRUCTION)
Build out St 205 - 35 Nod Rd Avon
LogiqS8 ultrasound machine
MOB RENOVATIONS
Phone System
SFMG Vernon Suite 200-201
Ultrasound machine/Sports medicine

Reallocation to Johnson Memorial - part of strategic growth of RHM

EPICARE-JOHNSON MEMORIAL MEDICAL CENTER
JMMC KRONOS/FRONTIER IMPLEMENTAION
JMMC PeopleSoft

Saint Mary's Epic Implementation
Saint Mary's-Epic & Labor FY17
Saint Mary's-Hardware FY17
Saint Mary's-Third Party Software FY17
Capital leases associated with Epic and other
Asset Adjustments
RECLASS
Grand Total

(Multiple Items)
Sum of Amount
2,744,912
5,990
13,797
15,909
74,147
(115,528)
1,010,293
320
274
464,916
35,127
30,410
183,642
9,824
(6,783)
(229,286)
2,482
304,442
142,340
-
54,082
14,841
2,200
561,658
73,155
93,389
3,270
3,075,449
983,929
6,652
11,870
80,957
103,776
79,673
663
23,657
464,125
2,555
361
962,422
301,625
4,749
48,435
2,565,492

6,508
60,588
197,873
(34,318)
172,286
1,170,494
661,965
7,732
33,969
6,506
172,125
4,167
58,319
47,278
7,152,038
13,676
4,175
2,565
222,365
10,735
4,496
8,619
880,902
24,100
9,900
14,234
211,177
47,869
8,500
14,100
77,919
(4,910)
(47,515)
6,000
3,942
1,020
11,705
4,965
256
50,328
(15,338)
16,988
17,358
109,475
118,142
(2,213)
1,311

12,433
25,325
69,411
617,382
500
(143,687)
124,006
22,859
7,005
16,525
8,744
10,640
233,746
1,205
140,433
40,504
75,341
24,780
69,444
3,053
(118)
7,250
8,000
(270)
115,301
26,520
(180,322)
(188,950)
(305,081)
151,067
3,808
7,780
(28,816)
66,686
133
262
(15,922)
(35,403)
(9,326)
131,043
14,851
(6,461)
4,509
100,000
19,056
3,104
313,038

6,298
19,065
(13,306)
6,342
69,719
4,470
133,629
508,753
334,675
1,137
1,236,315
93,530
3,925
348,793
50,383
5,203
5,760
(1,382)
175,000
5,186
52,000
96,000
73,561
46,165
3,085
-
66,308
52,030
48,500
32,208
40,103
7,500
3,941
5,834
243,075
1,029,339
110,542
17,190
-
392,486
7,733
459,964
41,424
844,662
15,739
412,756
416,167

29,249,149
20,269,815
4,821,428
4,157,906
9,113,990
1,298,154
7,815,836
55,775,030

DESCRIPTION	DEPT	QUAN	CLASS	TYPE
ARCHITECTUAL/MEP	7980	1	BLDG IMP	NONMEDICAL
ECG MACHINES MAC5500	7800	1	MOVEABLE	MEDICAL
20 BEDSIDE MOMITORS, 29 BASE & ANTENNAS	6140	40	MOVEABLE	MEDICAL
PRINTER, 260 CONNEX 3D	8320	1	MOVEABLE	NONMEDICAL
VERIGENIE READER INSTRUMENT	7361	1	MOVEABLE	MEDICAL
ELECTRONIC MOP & 2 BATTERIES	8100	1	MOVEABLE	NONMEDICAL
ADDITIONAL STORAGE FOR CAMERAS	8350	1	MOVEABLE	NONMEDICAL
CAMERA	8350	19	MOVEABLE	NONMEDICAL
STERIS 3023	7850	1	MOVEABLE	MEDICAL
LAB TURNAROUND OUTLIER	7361	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 VARIABLE HEIGHT	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
ULTRASOUND 101912 EPIQ 5G	7290	1	MOVEABLE	MEDICAL
VSD OPTICVIEW MICROPANEL	8300	1	MOVEABLE	NONMEDICAL
VSD OPTICVIEW MICROPANEL	8300	1	MOVEABLE	NONMEDICAL
APPLICATION & CERTIFICATE	8300	1	FIXED	NONMEDICAL
APPLICATION & CERTIFICATE	7980	1	FIXED	NONMEDICAL
VISION ELECTRIC	7980	1	FIXED	NONMEDICAL
UNBNDLD 2 NODE GEN 4LP	7280	1	MOVEABLE	NONMEDICAL
DOUBLE SPINDLE LIGHTS OR5	7010	1	MOVEABLE	NONMEDICAL
DOUBLE SPINDLE LIGHTS OR5	7010	1	MOVEABLE	NONMEDICAL
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL
FIRE PROTECTION PROJECT	8300	1	MOVEABLE	NONMEDICAL
EXHAUST FAN GARBAGE AREA	8300	1	MOVEABLE	NONMEDICAL
FIRE ALARM PANEL	8300	1	MOVEABLE	NONMEDICAL
SCOPE & MONITOR	7800	2	MOVEABLE	MEDICAL
APPLICATION & CERTIFICATE	7980	1	FIXED	NONMEDICAL
CHESHIRE PJT - CART	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT -TELEPHONE SYSTEM	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - FIBER INSTALL	7700	1	FIXED	NONMEDICAL
CHESHIRE PJT - SIGNS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - ARCHITECTURE	7700	1	BLDG IMP	NONMEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - CABINETS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - ARCHITECTURE	7700	1	BLDG IMP	NONMEDICAL
CHESHIRE PJT - CONSTRUCTION	7700	1	BLDG IMP	NONMEDICAL

CHESHIRE PJT - XRAY TESTING	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - EQUIPMENT	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MASCOT	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - CHAIRS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - WORKSTATION	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - FEE	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - FURNITURE	7700	1	MOVEABLE	NONMEDICAL
CATH LAB PJT - EQUIPMENT	7460	1	MOVEABLE	MEDICAL
CATH LAB PJT - CONSTRUCTION	7460	1	BLDG IMP	NONMEDICAL
CATH LAB PJT - ARCHITECTURE	7460	1	BLDG IMP	NONMEDICAL
CATH LAB PJT - EQUIPMENT	7460	1	MOVEABLE	MEDICAL
CHESHIRE PJT -ANALYZER	7700	1	MOVEABLE	MEDICAL
ENDOSCOPE 0 DEG, 8 MM	7010	1	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
POSITIONER DEMAYO 30" BASE	7010	2	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
SHIMADZU MOBILE	7850	1	MOVEABLE	MEDICAL
SCOPE INTUBATION FLEX	7220	1	MOVEABLE	MEDICAL
HOPKINS II TELESCOPE	7010	4	MOVEABLE	MEDICAL
HOPKINS II TELESCOPE	7010		MOVEABLE	MEDICAL
TIE IN VULCAN SECURITY SYSTEM	8350	1	FIXED	NONMEDICAL
TENNANT/NOBLES T2 SCRUBBER	8100	1	MOVEABLE	NONMEDICAL
EXHAUST FAN OUTSIDE GARABE AREA	8300	1	MOVEABLE	NONMEDICAL
HYSTERSCOPE	7850	1	MOVEABLE	MEDICAL
HYSTERSCOPE	7850	1	MOVEABLE	MEDICAL
AVALON FM50 FETAL MONITOR	7070	14	MOVEABLE	MEDICAL
AVALON FM50 FETAL MONITOR	7070	14	MOVEABLE	MEDICAL
SCOPE INTUBATION FLEX VIDEO	7220	1	MOVEABLE	MEDICAL
FIRE PREVENTION PROJECT	8300	1	MOVEABLE	NONMEDICAL
ACUSON SC2000 ULTRASOUND SYSTEM	7440	1	MOVEABLE	MEDICAL
WORKSTATION	7540	1	MOVEABLE	NONMEDICAL
DEFIBRILATORS R SERIES	8320	2	MOVEABLE	MEDICAL
FIRE PREVENTION PJT SM COMPUTER RM	8300	1	MOVEABLE	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL

REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
MOTOROLA SL7550E RADIO	8350	20	MOVEABLE	NONMEDICAL
MOTOROLA SL7550E RADIO	8350	20	MOVEABLE	NONMEDICAL
APPLICATION AND CERTIFICATE	7980	1	FIXED	NONMEDICAL
WOUNDCARE RENOVATION	7550		BLDG IMP	NONMEDICAL
WOUNDCARE RENOVATION	7550		BLDG IMP	NONMEDICAL
PROFESSIONAL DESIGN	8300	0	MOVEABLE	NONMEDICAL
HEMATOLOGY ANALYZER XN SERIES	7361	1	MOVEABLE	MEDICAL
NEXUS SECURE TRANS MNGMT STATION	7361	1	MOVEABLE	NONMEDICAL
SERVING COUNTER & REGISTER STAND	8000	1	MOVEABLE	NONMEDICAL
CSI SYSTEMS UPGRADE	8300	1	MOVEABLE	NONMEDICAL
END OF LIFE PACS COMPUTERS	7280	1	MOVEABLE	MEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
CHAIRS W/ ARMS	7280	12	MOVEABLE	NONMEDICAL
RENOVATIONS BLOOD DRAW	**7904**	**1**	**BLDG IMP**	**NONMEDICAL**
MICROSCOPE LENS & ACCESSORIES	7360	1	MOVEABLE	MEDICAL
MULTI DRIVE FRAME W/ HERCULES	6500	24	MOVEABLE	MEDICAL
MULTI DRIVE FRAME W/ HERCULES	6500	24	MOVEABLE	MEDICAL
DESIGNER JET PRINTER T2530	8300	1	MOVEABLE	NONMEDICAL
RECLINERS	3150	6	MOVEABLE	NONMEDICAL
RECLINERS	6200	4	MOVEABLE	NONMEDICAL
RECLINERS	3130	5	MOVEABLE	NONMEDICAL
RECLINERS	3320	3	MOVEABLE	NONMEDICAL
RECLINERS	3500	4	MOVEABLE	NONMEDICAL
RECLINERS	3140	2	MOVEABLE	NONMEDICAL
SPECTRUM IV PUMPS	8320	1	MOVEABLE	MEDICAL
SPECTRUM IV PUMPS	8320	1	MOVEABLE	MEDICAL
FLOORING/INSTALL	8300	1	FIXED	NONMEDICAL
STEAM GENERATOR	7850	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - TELEPHONE SYSTEM	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - PHARMACY FILTERS	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - COMPUTERS	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - CONSTRUCTION	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - ELECTRICAL	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - CABINET	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - DATA LINES	7936	1	FIXED	NONMEDICAL
ONCOLOGY PRJT - CONSTRUCTION	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - ARCHITECTURE	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - FURNITURE	7936	1	MOVEABLE	NONMEDICAL
WOUNDCARE PRJT - WALLS	7550	1	BLDG IMP	NONMEDICAL
WOUNDCARE PRJT - TV	7550	1	MOVEABLE	NONMEDICAL
RENOVATION - WATERTOWN BLOOD	**7904**	**1**	**BLDG IMP**	**NONMEDICAL**
RENOVATION - WOLCOTT UC	**7361**	**1**	**BLDG IMP**	**NONMEDICAL**
DATA LINES	7981	1	FIXED	NONMEDICAL
DATA LINES	7981	1	FIXED	NONMEDICAL

DATA LINES	7980	1	FIXED	NONMEDICAL
EXHAUST FAN - ANNEX CHILLER	8300	1	MOVEABLE	NONMEDICAL
TRANSDUCER/ MONITORS	7070	1	MOVEABLE	MEDICAL
CSI UPGRADE	8300	1	MOVEABLE	NONMEDICAL
OR INSTRUMENTS	7010	1	MOVEABLE	MEDICAL
RENoVATION WEST MAIN CARD	7901	1	BLDG IMP	NONMEDICAL
1981 E MAIN TENANTS WORK PAYOUT	7905	1	BLDG IMP	NONMEDICAL
MRI PRJT - BLDG IMP	7340	1	BLDG IMP	NONMEDICAL
MRI PRJT - FIXED	7340	1	FIXED	NONMEDICAL
MRI PRJT - LAND IMP	7340	1	LAND IMP	NONMEDICAL
MRI PRJT - MOVEABLE	7340	1	MOVEABLE	MEDICAL
ULTRASOUND 101912 EPIQ 5G	7290	1	MOVEABLE	MEDICAL
PARKING GARAGE DRAIN WORK	8300	1	BLDG IMP	NONMEDICAL
PARKING GARAGE DRAIN WORK	8300	1	BLDG IMP	NONMEDICAL
SIDEWALK AND WALL REPAIR	8300	1	BLDG IMP	NONMEDICAL
REPAIRS TO COLE STREET PARKING GARAGE	8300	1	BLDG IMP	NONMEDICAL
APPL AND CERT FOR PYMT FOR WEST MAIN CARDIO RENO\	8300	1	BLDG IMP	NONMEDICAL
ANALYE EMER POWER FOR GENERATOR ENG	8300	1	BUILD IMP	NONMEDICAL
PROF SRVS FOR ONCOLOGY PROJ LEEVER CTR PH 1 & 2 OF	7936	1	BUILD IMP	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	BUILD IMP	NONMEDICAL
AIR HANDLER REPLACEMT-NAUG UCC & PT	8300	1	FIXED	NONMEDICAL
AIR HANDLER REPLACEMT-NAUG UCC & PT	8300	1	FIXED	NONMEDICAL
SECURITY SYSTEM FOR ALL PATIENT AREAS	8350	1	FIXED	NONMEDICAL
SINK 120" TRIPLE BAY CLEANUP FIXED HT W/INSTALL	7570	1	FIXED	NONMEDICAL
ALPHA 7 SURGICAL ULTRASOUND SCANNER	7010	1	MOVEABLE	MEDICAL
BESIDE MONITOR SH3	6140	1	MOVEABLE	MEDICAL
FORCEPOINT V10K	9080	1	MOVEABLE	NONMEDICAL
TEST CARDINAL SERUM/URINE HCG RAPID	7905	1	MOVEABLE	MEDICAL
TRAINING MTRL-GUNSHOT WOUND BICEP W/SHIPPING	7800	1	MOVEABLE	MEDICAL
TRAINING MTRL-LEG AMPUTATION	7800	1	MOVEABLE	MEDICAL
TRAINING MTRL-GSW TO LEG	7800	1	MOVEABLE	MEDICAL
TACTICAL TRAINING MATERIALS	7800	1	MOVEABLE	MEDICAL
TABLE OVERBED ART CARE OAK AND BRIO BEDSIDE CABINI	8100	24	MOVEABLE	NONMEDICAL
SPEEDCHCK SOFTWARE & TOUCHSCREEN TERM FOR CASH	5800	1	MOVEABLE	NONMEDICAL
MICROSCOPE FRAME BX43F W/CLOTH ANTISTATIC DUSTCO	7360	1	MOVEABLE	MEDICAL
ROTATABLE NOSEPIECE U-RE 2.5 POS	7360	1	MOVEABLE	MEDICAL
BINOC OBSERV TUBE U-B130-2-2	7360	1	MOVEABLE	MEDICAL
RT HAND MECH STAGE RACKLESS, LONG W/LEFT RELEASE	7360	1	MOVEABLE	MEDICAL
VIDEO URETERO-RENOSCOPE FLEX-XC	7010	1	MOVEABLE	MEDICAL
8 FT OVAL CONF TABLE, NESTING SIDE CHAIRS, DESK & BLA	8300	1	MOVEABLE	NONMEDICAL
INSIGHT FD MINI C-ARM	7010	1	MOVEABLE	MEDICAL
VITRE EXTEND BASIC PACKAGE	7280	1	MOVEABLE	MEDICAL
SHIMADZU MOBILE MX7C W/SINGLE PANEL	7850	1	MOVEABLE	MEDICAL
SLEEP CHAIR	7070	10	MOVEABLE	NONMEDICAL
LABOR AND MTLS TO INSTALL WALL HUNG P SERIES MITSU	8300	1	FIXED	NON-MEDICAL
DISHWASHER-HOBART	8000	1	FIXED	NON-MEDICAL
HOSPITAL DOOR RELEASE	8300	1	FIXED	NON-MEDICAL

LABOR FOR CLEANING AREA & FURNITURE WATER DAMAGE	8300	1	FIXED	NON-MEDICAL
LAB & MAT 3801 E MAIN ST COUNTERTOP RT TO SINK	8300	1	FIXED	NON-MEDICAL
LAB & MAT INSTALL SECURITY SYSTEM ALL PT AREAS	8300	1	FIXED	NON-MEDICAL
LEEVER CT RENOVATIONS PHASE 2	8300	1	FIXED	NON-MEDICAL
GENERAL CONDITIONS, DRYWALL, FLOORING, ETC KITCHEN	8300	1	FIXED	NON-MEDICAL
LABOR MATERIALS EQUIPMENT CHAPLIN AREA	9180	1	FIXED	NON-MEDICAL
LABOR MATERIALS EQUIPMENT SECURITY PROJECT	8300	1	FIXED	NON-MEDICAL
FREIGHT IV PUMPS	8320	1	MOVEABLE	MEDICAL
PRIME BLADDER SCANNER W/ CART	7800	2	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
OVERBEDTABLE MAPLE	6500	24	MOVEABLE	NON-MEDICAL
HYDRASLIM SINGLEPORT SYSTEM	7800	2	MOVEABLE	MEDICAL
SMALL BLOOD POWER	7800	1	MOVEABLE	MEDICAL
AVALON FETAL MONITORS	7070	15	MOVEABLE	MEDICAL
REPROCESSOR ENDOSCOPE	7850	3	MOVEABLE	MEDICAL
COLONSCOPE W/DUAL FOCUS	7850	2	MOVEABLE	MEDICAL
VITRE EXTENDS BASIC	7280	1	MOVEABLE	MEDICAL
ADULT WATER RESCUE MANAKIN	7800	1	MOVEABLE	MEDICAL
FLS ALL IN ONE TRAINER SYSTEM	7881	1	MOVEABLE	MEDICAL
NEXUS SECURE TRANSACTION MGMT	7361	1	MOVEABLE	MEDICAL
VIDEO URETERO RENOSCOPE	7010	1	MOVEABLE	MEDICAL
PAVEMENT MARKING GARGAGE/ER-VALET-LOTS	8300	1	LAND IMP	NON-MEDICAL
MRI PROJECT #15-002 BLDG IMPR	7340	1	BLDG IMPR	NON-MEDICAL
E. MAIN PROJ #17-003 LEASEHOLD IMP	7905	1	BLDG IMPR	NON-MEDICAL
EPIC PROJ. BLDG IMPR	9080	1	BLDG IMPR	NON-MEDICAL
APPL& CERT. FOR LEEVER CLEAN RM	8300	1	FIXED	NON-MEDICAL
LABOR/MATERIAL HR-PAYROLL RENOVATIONS	8300	1	FIXED	NON-MEDICAL
E. MAIN PROJ #17-003 FIXED EQUIP.	7905	1	FIXED	NON-MEDICAL
EPIC PROJ. CAPITAL LABOR	9080	1	FIXED	NON-MEDICAL
TRANMISSION FOR HOSP TRUCK	7809	1	AUTO	NON-MEDICAL
OVERBED TABLE	6500	1	MOVEABLE	NON-MEDICAL
VIDEO URETERO RENOSCOPE	7010	1	MOVEABLE	MEDICAL
REMOVE/INSTALL STERILIZER/BOILER	7835	1	MOVEABLE	MEDICAL
INST. INTERFACE VAI SQ INST MGMT	7936	1	MOVEABLE	MEDICAL
TELESCOPE HOPKINS 11 0	7010	1	MOVEABLE	MEDICAL
NETWORK UPGRADES PROCESSBY TRINITY	9080	1	MOVEABLE	NON-MEDICAL
MRI PROJ #15-002 FURNITURE/OFFICE EQUIPMENT	7340	1	MOVEABLE	NON-MEDICAL
E. MAIN PROJ #17-003 COMPUTERS	7905	1	MOVEABLE	NON-MEDICAL
E. MAIN PROJ $17-003 FURNITURE/OFFICE EQUIP	7905	1	MOVEABLE	NON-MEDICAL
EPIC PROJ. COMPUTER EQUIP	9080	1	MOVEABLE	NON-MEDICAL
EPIC PROJ FURNITURE/OFFICE EQUIP	9080	1	MOVEABLE	NON-MEDICAL

Regular Additions
CIP Additions
TOTAL

ACQ DATE	ENTRY PER	LOCATION	AMT	VENDOR	PO
4/30/2017	07/2017	SLEEP LAB	970.00	MOSER	1709807
4/30/2017	07/2017	EMER	11,369.82	GE - 17858	1709089
4/30/2017	07/2017	TELEMETRY	578,971.45	PHILIPS - 18801	1706061
4/30/2017	07/2017	CLINICAL ENG	24,730.00	STRATASYS	1709090
4/30/2017	07/2017	MICRO LAB	55,000.00	NANOSPHERE	1709971
4/30/2017	07/2017	ENVIRON	4,850.00	MEDLINE	1710344
4/30/2017	07/2017	SECURITY	15,800.00	STERLING	1707442
4/30/2017	07/2017	SECURITY	29,077.00	STERLING	1705797
4/30/2017	07/2017	NVSC	12,211.30	MEDIQUIP	1710192
4/30/2017	07/2017	LAB	3,305.00	SUNQUEST	1705251
4/30/2017	07/2017	OR	378,845.27	KARL STORZ	1709660
4/30/2017	07/2017	OR	4,425.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	31,050.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	10,350.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	(931.50)	KARL STORZ	1709660
4/30/2017	07/2017	OR	(11,646.61)	KARL STORZ	1709660
4/30/2017	07/2017	OR	27,929.02	KARL STORZ	1709660
4/30/2017	07/2017	OR	(132.75)	KARL STORZ	1709660
4/30/2017	07/2017	ULTRASOUND	120,261.30	PHILIPS - 18801	1706888
4/30/2017	07/2017	PLANT	91,390.00	JOHNSON CONTROLS	1706358
4/30/2017	07/2017	PLANT	(71,307.00)	JOHNSON CONTROLS	1706358
4/30/2017	07/2017	PLANT	88,098.61	O and G	1709019
4/30/2017	07/2017	SLEEP LAB	62,369.98	O and G	1709021
4/30/2017	07/2017	SLEEP LAB	9,172.00	O and G	1709173
4/30/2017	07/2017	RAD	24,245.90	CDW	1707678
4/30/2017	07/2017	OR	13,419.87	STERIS	1710054
4/30/2017	07/2017	OR	(3,022.97)	STERIS	1710054
4/30/2017	07/2017	FOOD	7,226.34	PERFORMANCE INT	1705599
4/30/2017	07/2017	FOOD	(29.81)	PERFORMANCE INT	1705599
4/30/2017	07/2017	PLANT	80,757.00	NEWMACK	1618556
4/30/2017	07/2017	PLANT	2,099.00	GOOD HILL	1710034
4/30/2017	07/2017	PLANT	1,820.00	CPE ELECTRIC	1705421
4/30/2017	07/2017	ED	4,590.88	TRI ANIM	1711247
4/30/2017	07/2017	SLEEP LAB	28,108.98	O and G	1709023
5/31/2017	08/2017	CHESHIRE UC	5,740.00	ARMSTRONG	1618392
5/31/2017	08/2017	CHESHIRE UC	234,166.26	ATRION NETWRKING	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	391.00	BURLINGTON MED	1614339
5/31/2017	08/2017	CHESHIRE UC	5,046.52	CARDINAL	1614845
5/31/2017	08/2017	CHESHIRE UC	1,952.10	CDW	16130.5
5/31/2017	08/2017	CHESHIRE UC	750.00	CHIMENET	NA
5/31/2017	08/2017	CHESHIRE UC	12,615.00	CONNECTICUT SIGNCRA	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	83,427.03	CROSSKEY	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	42,450.55	DELL MARKETING	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	14,300.00	DISPLAY WRIGHT	1708807
5/31/2017	08/2017	CHESHIRE UC	36,700.75	FLETCHER THOMPSON	NA
5/31/2017	08/2017	CHESHIRE UC	1,253,371.76	FORTUNATO CONSTRUC	VARIOS

5/31/2017	08/2017	CHESHIRE UC	1,200.00	GJ RANDALL MS	NA
5/31/2017	08/2017	CHESHIRE UC	13,162.85	GOV CONNECTION	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	344.32	GRAINGER	1618393
5/31/2017	08/2017	CHESHIRE UC	5,304.00	LANDMARK	NA
5/31/2017	08/2017	CHESHIRE UC	1,457.00	MARKETLAB	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	25,507.91	MCKESSON	1614881
5/31/2017	08/2017	CHESHIRE UC	20,004.02	MERGE HEALTHCARE	1614354
5/31/2017	08/2017	CHESHIRE UC	103,492.00	PARKER- XRAY	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	575.00	STATE OF CT	NA
5/31/2017	08/2017	CHESHIRE UC	30,235.82	WB MASON	VARIOUS
5/31/2017	08/2017	CATH LAB	14,376.53	CAROUSEL IND	1611912
5/31/2017	08/2017	CATH LAB	74,399.26	O AND G	VARIOUS
5/31/2017	08/2017	CATH LAB	24,835.39	MOSER PILON	VARIOUS
5/31/2017	08/2017	CATH LAB	577,188.00	SIEMENS	1609980
5/31/2017	08/2017	CHESHIRE UC	15,888.00	ABBOT LAB	1615143
5/31/2017	08/2017	SURGERY	9,000.00	INTUITIVE SURGICAL	1711486
5/31/2017	08/2017	OR	295.92	STERIS	1707248
5/31/2017	08/2017	OR	(174.59)	STERIS	1707248
5/31/2017	08/2017	OR	12,040.00	INNOVATION	1711440
5/31/2017	8/2017	NVSC	7,590.00	ARTHREX	1711438
5/31/2017	8/2017	NVSC	37,216.00	ARTHREX	1711438
5/31/2017	8/2017	NVSC	1,130.00	ARTHREX	1711438
12/31/2016	03/2017	CENTRAL STER	24,771.80	CARDINAL	1704227
12/31/2016	03/2017	CENTRAL STER	(42,284.30)	CARDINAL HEALTH	1704227
12/31/2016	03/2017	CENTRAL STER	18,685.30	CARDINAL	1704227
5/31/2017	08/2017	NVSC	14,300.00	MEDICAL IMAGING	1711740
5/31/2017	08/2017	ANES	6,840.00	KARL STORZ	1711770
5/31/2017	08/2017	SURGERY	29,564.20	KARL STORZ	1711630
5/31/2017	08/2017	SURGERY	(837.90)	KARL STORZ	1711630
5/31/2017	8/2017	SECURITY	14,960.00	TPC	1711728
5/31/2017	08/2017	ENVIRONMENTAL	4,116.87	GRAINGER	1710338
5/31/2017	08/2017	PLANT	2,099.00	GOOD HILL	1710034
5/31/2017	08/2017	NVSC	35,678.00	HOLOGIC	1711431
5/31/2017	08/2017	NVSC	(11,064.79)	HOLOGIC	1711431
5/31/2017	08/2017	LABOR AND DELIVERY	66,891.40	PHILIPS 18801	1707758
5/31/2017	08/2017	LABOR AND DELIVERY	138,284.10	PHILIPS 18801	1707758
5/31/2017	08/2017	ANES	6,840.00	KARL STORZ	1712318
5/31/2017	08/2017	PLANT	63,563.00	NEWMACK	1619956
5/31/2017	08/2017	ELETRO CARDO	216,872.00	SIEMENS 20981	1710047
5/31/2017	08/2017	CCU	5,106.00	DRAEGER	1614693
5/31/2017	08/2017	CLINICL	28,853.00	ZOLL	1707444
5/31/2017	08/2017	PLANT	24,567.00	NEWMACK	1619957
5/31/2017	08/2017	PLANT	16,000.00	HERITAGE	1711844
5/31/2017	08/2017	PLANT	44,950.00	HERITAGE	1702785
5/31/2017	08/2017	PLANT	(13,485.00)	HERITAGE	1702785
5/31/2017	08/2017	PLANT	14,000.00	HERITAGE	1711838
5/31/2017	08/2017	PLANT	(2,800.00)	HERITAGE	1711838

5/31/2017	08/2017	PLANT	(33,710.47)	JOHNSON CONTROL	1706358
5/31/2017	08/2017	PLANT	33,710.47	JOHNSON CONTROL	1706358
5/31/2017	08/2017	PLANT	23,969.06	JOHNSON CONTROL	1706358
5/31/2017	08/207	SECURITY	22,834.20	NORTHEASTERN COMM	1705583
5/31/2017	08/207	SECURITY	1,105.00	NORTHEASTERN COMM	1705583
4/30/2017	07/2017	SLEEP LAB	14,043.49	O AND G	1711475
5/31/2017	08/2017	PLANT	49,750.00	O AND G	1705373
5/31/2017	08/2017	PLANT	10,985.00	O AND G	1705373
12/31/2016	03/2017	PLANT	(1,400.00)	MILONE	1620105
6/30/2017	09/2017	LAB	147,918.00	SYSMEX AMER	1710210
6/30/2017	09/2017	LAB	179,499.25	TRANSLOGIC CORP	1705886
6/30/2017	09/2017	FOOD	14,674.81	WAREHOUSE STORE FIX	1710049
6/30/2017	09/2017	PLANT	49,700.00	SIEMENS IND	1711346
6/30/2017	09/2017	RAD	107,297.99	MERGE HEALTHCARE	1711779
6/30/2017	09/2017	PLANT	13,485.00	HERITAGE	1702785
6/30/2017	09/2017	RAD	5,062.56	WB MASON	1709423
6/30/2017	**09/2017**	**WOLCOTT UC**	**38,215.40**	**CLASSIC BLDRS**	**1714251**
6/30/2017	09/2017	MICRO LAB	3,015.61	OLYMPUS 16331	1714056
6/30/2017	09/2017	CCU	662,028.76	LINET AMERICAS	1711273
6/30/2017	09/2017	CCU	(3,840.00)	LINET AMERICAS	1711273
6/30/2017	09/2017	PLANT	9,150.00	WB MASON	1714384
6/30/2017	09/2017	OB4	9,799.92	WB MASON	1710438
6/30/2017	09/2017	OB7	6,205.64	WB MASON	1710438
6/30/2017	09/2017	SH5	7,762.05	WB MASON	1710438
6/30/2017	09/2017	X3	4,654.23	WB MASON	1710438
6/30/2017	09/2017	CCU	6,201.64	WB MASON	1710438
6/30/2017	09/2017	TELE	3,101.70	WB MASON	1710438
6/30/2017	09/2017	CLINICAL	3,750.00	BAXTER	1713941
6/30/2017	09/2017	CLINICAL	92,500.00	BAXTER	1713941
6/30/2017	09/2017	PLANT	16,459.34	WB MASON	1608995BL
6/30/2017	09/2017	NVSC	12,211.30	MEDIQUIP	1710192
6/30/2017	09/2017	ONCOLOGY	52,227.60	ATRION NETWORKING	1617300
6/30/2017	09/2017	ONCOLOGY	4,730.00	BUCKLEY	1702117
6/30/2017	09/2017	ONCOLOGY	44,282.41	CDW COMPUTERS	1703192/01
6/30/2017	09/2017	ONCOLOGY	2,300.00	ENGINEERED	NA
6/30/2017	09/2017	ONCOLOGY	36,415.00	GOOD HILL	1611146
6/30/2017	09/2017	ONCOLOGY	24,972.00	LM AIR TECH	1610246
6/30/2017	09/2017	ONCOLOGY	19,615.79	MID-STATE TELEDATA	1702426
6/30/2017	09/2017	ONCOLOGY	987,316.63	STANDARD BUILDERS	VARIOUS
6/30/2017	09/2017	ONCOLOGY	134,841.11	TECTON ARCH	VARIOUS
6/30/2017	09/2017	ONCOLOGY	77,485.60	WB MASON	1616845
6/30/2017	09/2017	WOUNDCARE	6,273.90	INPRO CORPORATION	1706596
6/30/2017	09/2017	WOUNDCARE	850.25	TELEHEALTH	1710200
6/30/2017	**09/2017**	**WATERTOWN BLOOD**	**18,092.90**	**CLASSIC BLDRS**	**1714251**
6/30/2017	**09/2017**	**WOLCOTT UC**	**20,122.50**	**CLASSIC BLDRS**	**1714251**
6/30/2017	09/2017	SLEEP WOLCOTT	1,360.00	MID-STATE TELEDATA	1707588
6/30/2017	09/2017	SLEEP WOLCOTT	625.00	MID-STATE TELEDATA	1707588

6/30/2017	09/2017		SLEEP WTBY	615.00	MID-STATE TELEDATA	1707588
6/30/2017	09/2017		PLANT	41,077.00	SARRACCO	1713007
6/30/2017	09/2017		WIC	3,154.04	PHILIPS - 18801	1707758
6/30/2017	09/2017		PLANT	52,800.00	SIEMENS IND	1711346
6/30/2017	09/2017		OR	20,394.00	SOLOS END	1712323
6/30/2017	09/2017		CARDIO	98,752.50	BISMARCK	1715305
6/30/2017	09/2017		EAST MAIN	704,062.18	YAMIN & GRANT LLC	NA
6/30/2017	09/2017		MRI	4,796,329.63	VARIOUS	VARIOUS
6/30/2017	09/2017		MRI	33,066.00	MID-STATE TELEDATA	1701701
6/30/2017	09/2017		MRI	23,765.50	ALL LAWN CARE	VARIOUS
6/30/2017	09/2017		MRI	764,167.16	TELEHEALTH	VARIOUS
4/30/2017	07/2017		ULTRASOUND	(112,861.30)	PHILIPS - 18801	1706888
42947		10	PLANT	7,200.00	JOHN'S ASPHALT	1713175
42947		10	PLANT	16,300.00	JOHN'S ASPHALT	1713265
42947		10	PLANT	69,500.00	JOHN'S ASPHALT	1715631
42947		10	PLANT	34,759.00	BISMARCK	1713189
42947		10	PLANT	115,955.00	BISMARCK	1715627
42947		10	PLANT	118,850.00	SODEXHO	1715617
42947		10	ONCOLOGY	2,793.86	TECTON ARCHITECTS	1611961
42947		10	PLANT	13,627.47	JOHNSON CONTROL	1706358
42947		10	PLANT	14,250.00	GOODHILL	1715038
42947		10	PLANT	14,250.00	GOODHILL	1715038
42947		10	SECURITY	229,927.14	VULCAN SECURITY	1711726
42947		10	CENTRAL STERILE	15,357.85	STERIS	1711433
42947		10	SURG UNIT	151,922.75	HITACHI	1716221
42947		10	TELEMETRY	(5,391.88)	PHILIPS	1706061
42947		10	IT	17,091.00	K LOGIC	1715123
42947		10	EAST MAIN-UCC	23.19	CARDINAL	1715563
42947		10	EMER RM	1,697.00	TECHLINE	1714730
42947		10	EMER RM	888.25	TECHLINE	1714730
42947		10	EMER RM	516.38	TECHLINE	1714730
42947		10	EMER RM	6,444.67	NORTH AMERICAN	1714870
42947		10	ENVIROMENT	18,011.52	HILL ROM	1710342
42947		10	CAFÉ	5,819.85	NCR OF NEW ENGLAND	1710053
42947		10	LAB	1,172.76	OLYMPUS AMER	1714056
42947		10	LAB	347.13	OLYMPUS AMER	1714056
42947		10	LAB	834.33	OLYMPUS AMER	1714056
42947		10	LAB	476.76	OLYMPUS AMER	1714056
42947		10	SURG UNIT	3,952.55	KARL STORZ	1714095
42947		10	PLANT	4,131.00	HUDSON VALLEY OFFCIE FU	1715616
42947		10	SURG UNIT	69,500.00	HOLOGIC	1715256
42947		10	RADIOLOGY	72,155.20	TOSHIBA	1709559
42947		10	NVSC	128,700.00	MEDICAL IMAGING	1711740
42947		10	LABOR & DELIVERY	14,892.60	WB MASON	1711397
08/31/2017		11	FACILITIES	9,676.00	SARRACCO	1714588
08/31/2017		11	CAFÉ	74,568.74	SODEXCO	1706461
08/31/2017		11	FACILITIES	15,609.00	SIMPLEX	1711729

08/31/2017	11	FACILITIES	750.00	CHAMPION	1717634
08/31/2017	11	FACILITIES	1,015.00	CHAMPION	1716633
08/31/2017	11	FACILITIES	11,346.82	VULCAN	1711726
08/31/2017	11	FACILITIES	167.50	TECTON	1611923
08/31/2017	11	FACILITIES	47,226.00	O AND G	1714580
08/31/2017	11	CHAPLIN	49,114.89	O AND G	1714083
08/31/2017	11	FACILITIES	12,609.90	O AND G	1715220
08/31/2017	11	CLINCIAL ENG	96.00	BAXTER	1713941
08/31/2017	11	EMER DEPT	22,000.00	VERATHON	1715989
08/31/2017	11	SURG UNIT	121.33	STERIS	1716725
08/31/2017	11	CCU	11,709.60	LINET AM	1714323
08/31/2017	11	EMER DEPT	5,951.41	TECHLINE	1714730
08/31/2017	11	EMER DEPT	114.00	TECHLINE	1714730
08/31/2017	11	WIC	8,219.00	PHILLIPS	1707758
08/31/2017	11	NVSC	90,632.07	OLYMPUS	1714665
08/31/2017	11	NVSC	173,915.14	OLYMPUS	1714662
08/31/2017	11	RADIOLOGY	18,038.80	TOSHBIA	1709559
08/31/2017	11	EMER DEPT	639.00	ALLIED 100	1714734
08/31/2017	11	SURG REG	13,263.52	LIMBS & THINGS	1716127
08/31/2017	11	LAB SENT OUT	30,355.25	TRANSLOGIC	1705886
08/31/2017	11	SURG UNIT	9,994.95	KARL STORZ	1718078
09/30/2017	12	PLANT	7,250.00	ARROW LINE PAINTING	1713176
09/30/2017	12	MRI	140,254.87	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	2,413,153.43	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	794,393.95	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	PLANT	39,347.74	STANDARD BUILDING	1718598
09/30/2017	12	PLANT	24,640.00	CHAMPION	1715306
09/30/2017	12	E MAIN CTR	126,685.32	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	11,659,632.71	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	STOREROOM	2,750.00	BLASIUS	N/A
09/30/2017	11	PLANT	(597.60)	LINET	1714323
08/31/2017	11	SURG UNIT	(5,054.85)	KARL STORZ	1718078
09/30/2017	12	NVSC	10,950.00	DESCO	1716033
09/30/2017	12	BOWEN	7,875.00	SUNQUEST	1712255
09/30/2017	12	SURG UNIT	12,084.00	KARL STORZ	1711630
09/30/2017	12	IT	886,766.10	TRINITY	N/A
09/30/2017	12	MRI	52,359.64	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	16,217.50	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	175,317.45	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	13,844,831.76	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	63,613.15	VARIOUS-SEE NOTES	SEE NOTES

$ 46,400,352.98
$ (9,841,443.79)
$ 36,558,909.19

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120	Sep-17

Explanation

1 new ARCHITECTUAL/MEP
1 new ECG MACHINES MAC5500
40 new 20 BEDSIDE MOMITORS, 29 BASE & ANTENNAS
1 new PRINTER, 260 CONNEX 3D
1 new VERIGENIE READER INSTRUMENT
1 new ELECTRONIC MOP & 2 BATTERIES
1 new ADDITIONAL STORAGE FOR CAMERAS
19 new CAMERA
1 new STERIS 3023
1 new LAB TURNAROUND OUTLIER
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 VARIABLE HEIGHT
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new ULTRASOUND 101912 EPIQ 5G
1 new VSD OPTICVIEW MICROPANEL
1 new VSD OPTICVIEW MICROPANEL
1 new APPLICATION & CERTIFICATE
1 new APPLICATION & CERTIFICATE
1 new VISION ELECTRIC
1 new UNBNDLD 2 NODE GEN 4LP
1 new DOUBLE SPINDLE LIGHTS OR5
1 new DOUBLE SPINDLE LIGHTS OR5
1 new GAS CHARBOILER
1 new GAS CHARBOILER
1 new FIRE PROTECTION PROJECT
1 new EXHAUST FAN GARBAGE AREA
1 new FIRE ALARM PANEL
2 new SCOPE & MONITOR
1 new APPLICATION & CERTIFICATE
1 new CHESHIRE PJT - CART
1 new CHESHIRE PJT -TELEPHONE SYSTEM
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - FIBER INSTALL
1 new CHESHIRE PJT - SIGNS
1 new CHESHIRE PJT - ARCHITECTURE
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - CABINETS
1 new CHESHIRE PJT - ARCHITECTURE
1 new CHESHIRE PJT - CONSTRUCTION

1 new CHESHIRE PJT - XRAY TESTING
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - EQUIPMENT
1 new CHESHIRE PJT - MASCOT
1 new CHESHIRE PJT - CHAIRS
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - WORKSTATION
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - FEE
1 new CHESHIRE PJT - FURNITURE
1 new CATH LAB PJT - EQUIPMENT
1 new CATH LAB PJT - CONSTRUCTION
1 new CATH LAB PJT - ARCHITECTURE
1 new CATH LAB PJT - EQUIPMENT
1 new CHESHIRE PJT -ANALYZER
1 new ENDOSCOPE 0 DEG, 8 MM
1 new LIGHT HANDLE CAMERA COVER
1 new LIGHT HANDLE CAMERA COVER
2 new POSITIONER DEMAYO 30" BASE
1 new SURGICAL EQUIPMENT
1 new SURGICAL EQUIPMENT
1 new SURGICAL EQUIPMENT
10 new CART W ACCESSORIES
10 new CART W ACCESSORIES
10 new CART W ACCESSORIES
1 new SHIMADZU MOBILE
1 new SCOPE INTUBATION FLEX
4 new HOPKINS II TELESCOPE
new HOPKINS II TELESCOPE
1 new TIE IN VULCAN SECURITY SYSTEM
1 new TENNANT/NOBLES T2 SCRUBBER
1 new EXHAUST FAN OUTSIDE GARABE AREA
1 new HYSTERSCOPE
1 new HYSTERSCOPE
14 new AVALON FM50 FETAL MONITOR
14 new AVALON FM50 FETAL MONITOR
1 new SCOPE INTUBATION FLEX VIDEO
1 new FIRE PREVENTION PROJECT
1 new ACUSON SC2000 ULTRASOUND SYSTEM
1 new WORKSTATION
2 new DEFIBRILATORS R SERIES
1 new FIRE PREVENTION PJT SM COMPUTER RM
1 new ROOF
1 new ROOF - CENTRAL PLANT
1 new ROOF - CENTRAL PLANT
1 new ROOF
1 new ROOF

1 new REMOVE & INSTALL TRANSDUCER
1 new REMOVE & INSTALL TRANSDUCER
1 new REMOVE & INSTALL TRANSDUCER
20 new MOTOROLA SL7550E RADIO
20 new MOTOROLA SL7550E RADIO
1 new APPLICATION AND CERTIFICATE
new WOUNDCARE RENOVATION
new WOUNDCARE RENOVATION
0 new PROFESSIONAL DESIGN
1 new HEMATOLOGY ANALYZER XN SERIES
1 new NEXUS SECURE TRANS MNGMT STATION
1 new SERVING COUNTER & REGISTER STAND
1 new CSI SYSTEMS UPGRADE
1 new END OF LIFE PACS COMPUTERS
1 new ROOF - CENTRAL PLANT
12 new CHAIRS W/ ARMS
1 new RENOVATIONS BLOOD DRAW
1 new MICROSCOPE LENS & ACCESSORIES
24 new MULTI DRIVE FRAME W/ HERCULES
24 new MULTI DRIVE FRAME W/ HERCULES
1 new DESIGNER JET PRINTER T2530
6 new RECLINERS
4 new RECLINERS
5 new RECLINERS
3 new RECLINERS
4 new RECLINERS
2 new RECLINERS
1 new SPECTRUM IV PUMPS
1 new SPECTRUM IV PUMPS
1 new FLOORING/INSTALL
1 new STEAM GENERATOR
1 new ONCOLOGY PRJT - TELEPHONE SYSTEM
1 new ONCOLOGY PRJT - PHARMACY FILTERS
1 new ONCOLOGY PRJT - COMPUTERS
1 new ONCOLOGY PRJT - CONSTRUCTION
1 new ONCOLOGY PRJT - ELECTRICAL
1 new ONCOLOGY PRJT - CABINET
1 new ONCOLOGY PRJT - DATA LINES
1 new ONCOLOGY PRJT - CONSTRUCTION
1 new ONCOLOGY PRJT - ARCHITECTURE
1 new ONCOLOGY PRJT - FURNITURE
1 new WOUNDCARE PRJT - WALLS
1 new WOUNDCARE PRJT - TV
1 new RENOVATION - WATERTOWN BLOOD
1 new RENOVATION - WOLCOTT UC
1 new DATA LINES
1 new DATA LINES

1 new DATA LINES
1 new EXHAUST FAN - ANNEX CHILLER
1 new TRANSDUCER/ MONITORS
1 new CSI UPGRADE
1 new OR INSTRUMENTS
1 new RENoVATION WEST MAIN CARD
1 new 1981 E MAIN TENANTS WORK PAYOUT
1 new MRI PRJT - BLDG IMP
1 new MRI PRJT - FIXED
1 new MRI PRJT - LAND IMP
1 new MRI PRJT - MOVEABLE
1 new ULTRASOUND 101912 EPIQ 5G
1 new PARKING GARAGE DRAIN WORK
1 new PARKING GARAGE DRAIN WORK
1 new SIDEWALK AND WALL REPAIR
1 new REPAIRS TO COLE STREET PARKING GARAGE
1 new APPL AND CERT FOR PYMT FOR WEST MAIN CARDIO RENOV
1 new ANALYE EMER POWER FOR GENERATOR ENG
1 new PROF SRVS FOR ONCOLOGY PROJ LEEVER CTR PH 1 & 2 OPM
1 new REMOVE & INSTALL TRANSDUCER
1 new AIR HANDLER REPLACEMT-NAUG UCC & PT
1 new AIR HANDLER REPLACEMT-NAUG UCC & PT
1 new SECURITY SYSTEM FOR ALL PATIENT AREAS
1 new SINK 120" TRIPLE BAY CLEANUP FIXED HT W/INSTALL
1 new ALPHA 7 SURGICAL ULTRASOUND SCANNER
1 new BESIDE MONITOR SH3
1 new FORCEPOINT V10K
1 new TEST CARDINAL SERUM/URINE HCG RAPID
1 new TRAINING MTRL-GUNSHOT WOUND BICEP W/SHIPPING
1 new TRAINING MTRL-LEG AMPUTATION
1 new TRAINING MTRL-GSW TO LEG
1 new TACTICAL TRAINING MATERIALS
24 new TABLE OVERBED ART CARE OAK AND BRIO BEDSIDE CABINETS
1 new SPEEDCHCK SOFTWARE & TOUCHSCREEN TERM FOR CASH REGISTERS
1 new MICROSCOPE FRAME BX43F W/CLOTH ANTISTATIC DUSTCOVER & POWERCORD
1 new ROTATABLE NOSEPIECE U-RE 2.5 POS
1 new BINOC OBSERV TUBE U-B130-2-2
1 new RT HAND MECH STAGE RACKLESS, LONG W/LEFT RELEASE HOLDER
1 new VIDEO URETERO-RENOSCOPE FLEX-XC
1 new 8 FT OVAL CONF TABLE, NESTING SIDE CHAIRS, DESK & BLACK MESH CONF CHAIRS
1 new INSIGHT FD MINI C-ARM
1 new VITRE EXTEND BASIC PACKAGE
1 new SHIMADZU MOBILE MX7C W/SINGLE PANEL
10 new SLEEP CHAIR
1 new LABOR AND MTLS TO INSTALL WALL HUNG P SERIES MITSUBISHI COOLING FOR 8TH FL IT CLOSET
1 new DISHWASHER-HOBART
1 new HOSPITAL DOOR RELEASE

1 new LABOR FOR CLEANING AREA & FURNITURE WATER DAMAGE
1 new LAB & MAT 3801 E MAIN ST COUNTERTOP RT TO SINK
1 new LAB & MAT INSTALL SECURITY SYSTEM ALL PT AREAS
1 new LEEVER CT RENOVATIONS PHASE 2
1 new GENERAL CONDITIONS, DRYWALL, FLOORING, ETC KITCHEN
1 new LABOR MATERIALS EQUIPMENT CHAPLIN AREA
1 new LABOR MATERIALS EQUIPMENT SECURITY PROJECT
1 new FREIGHT IV PUMPS
2 new PRIME BLADDER SCANNER W/ CART
1 new LIGHT HANDLE CAMERA COVER
24 new OVERBEDTABLE MAPLE
2 new HYDRASLIM SINGLEPORT SYSTEM
1 new SMALL BLOOD POWER
15 new AVALON FETAL MONITORS
3 new REPROCESSOR ENDOSCOPE
2 new COLONSCOPE W/DUAL FOCUS
1 new VITRE EXTENDS BASIC
1 new ADULT WATER RESCUE MANAKIN
1 new FLS ALL IN ONE TRAINER SYSTEM
1 new NEXUS SECURE TRANSACTION MGMT
1 new VIDEO URETERO RENOSCOPE
1 new PAVEMENT MARKING GARGAGE/ER-VALET-LOTS
1 new MRI PROJECT #15-002 BLDG IMPR
1 new E. MAIN PROJ #17-003 LEASEHOLD IMP
1 new EPIC PROJ. BLDG IMPR
1 new APPL& CERT. FOR LEEVER CLEAN RM
1 new LABOR/MATERIAL HR-PAYROLL RENOVATIONS
1 new E. MAIN PROJ #17-003 FIXED EQUIP.
1 new EPIC PROJ. CAPITAL LABOR
1 new TRANMISSION FOR HOSP TRUCK
1 new OVERBED TABLE
1 new VIDEO URETERO RENOSCOPE
1 new REMOVE/INSTALL STERILIZER/BOILER
1 new INST. INTERFACE VAI SQ INST MGMT
1 new TELESCOPE HOPKINS 11 0
1 new NETWORK UPGRADES PROCESSBY TRINITY
1 new MRI PROJ #15-002 FURNITURE/OFFICE EQUIPMENT
1 new E. MAIN PROJ #17-003 COMPUTERS
1 new E. MAIN PROJ $17-003 FURNITURE/OFFICE EQUIP
1 new EPIC PROJ. COMPUTER EQUIP
1 new EPIC PROJ FURNITURE/OFFICE EQUIP

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processed by St Francis	CIP project that was completed and moved to FA in FY17

User, OHCA

From: Cotto, Carmen
Sent: Friday, December 29, 2017 1:52 PM
To: Capone, Claudio
Cc: Roberts, Karen; User, OHCA
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Claudio,

A review of OHCA's compliance records indicated that due material related to Saint Mary's Docket Number 15-32045-CON Stipulation #12 has not been submitted to OHCA.

- Stipulation #12 states:

  "TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.
  In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

  a. *On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."*

Thirty date of the closing is August 31st, however, through previous email correspondence, dated May 25, May 16 and February 24, 2017, the Applicants and OHCA agreed that the material related to Condition #12 may instead be filed each November 30th. Therefore, the material is now overdue.

Please provide a response to the above CON compliance inquiry by January 12, 2017, two weeks from today. Please also remember to send to the OHCA general email inbox, which is OHCA@ct.gov , all material for the Docket. Please be assured that any material that will be received in the general inbox will become part of the public record for this docket number.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access

Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Sent: Wednesday, January 17, 2018 2:11 PM
To: Cotto, Carmen
Cc: Roberts, Karen; User, OHCA
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Carmen…I will follow through on this and get an update.

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, January 17, 2018 2:03 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: [EXTERNAL] RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Hi Claudio,

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Thank you,
Carmen

Carmen Cotto, MBA
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P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

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From: Cotto, Carmen
Sent: Friday, December 29, 2017 1:52 PM
To: 'Capone, Claudio' <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Carmen

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User, OHCA

From: Cotto, Carmen
Sent: Monday, January 22, 2018 10:04 AM
To: Lydia Shen; Roberts, Karen; User, OHCA
Cc: Capone, Claudio; Chris Hayes; Kyle Jurczyk; Keon Blackledge
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Follow Up Flag: Follow up
Flag Status: Completed

Hi Lydia,

We will let you know if we need anything else once the review of the documents is completed.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
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From: Lydia Shen [mailto:Lydia.Shen@TrinityHealthOfNE.Org]
Sent: Friday, January 19, 2018 2:20 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Chris Hayes <CHayes@Stmh.org>; Kyle Jurczyk <Kyle.Jurczyk@stmh.org>; Keon Blackledge <keon.blackledge@Stmh.org>
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hello Carmen,

Please find attached the requested information for Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

We apologize again for the delay. If you have any questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

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Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: [EXTERNAL] RE: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Subject: RE: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Carmen,

I'm working with Claudio and the team at Saint Mary's to pull this information together. We anticipate submitting it by end of day tomorrow.

We apologize for the delay.

Regards,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

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W 860-714-6579

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Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

From: "Cotto, Carmen" <Carmen.Cotto@ct.gov>
Date: January 17, 2018 at 2:02:50 PM EST
To: "Capone, Claudio" <Claudio.Capone@TrinityHealthOfNE.org>
Cc: "Roberts, Karen" <Karen.Roberts@ct.gov>, "User, OHCA" <OHCA@ct.gov>
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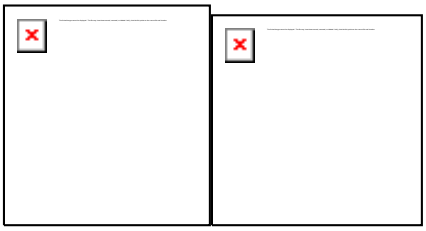
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



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User, OHCA

From: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Sent: Wednesday, January 31, 2018 11:54 AM
To: Cotto, Carmen; Roberts, Karen; User, OHCA
Cc: Capone, Claudio; Chris Hayes; Kyle Jurczyk; Natalie Cummings
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up
Attachments: Saint Mary's DN 15-32045 Reponse to Stipulation #12 - 01.31.2018.pdf

Good morning Carmen,

Attached, please find the information in response to the follow up question regarding Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

If you have additional questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, January 30, 2018 2:37 PM
To: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Subject: [EXTERNAL] FW: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and **NEVER** provide your Password.

Hi Lydia,

A review of the documents submitted to OHCA on January 19th related to Saint Mary's Docket Number 15-32045-CON Stipulation #12 indicates that it is missing information for FY 2017. The documents provided data

and related narratives for FY 2015 and FY 2016 Saint Mary's Community Benefits and Community Building Activities but not for FY 2017. Please provide the missing information.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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www.ct.gov/dph

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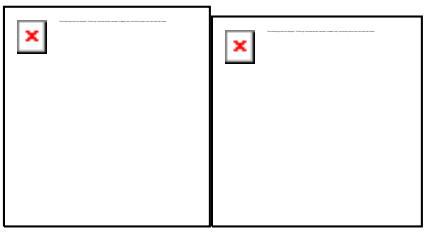

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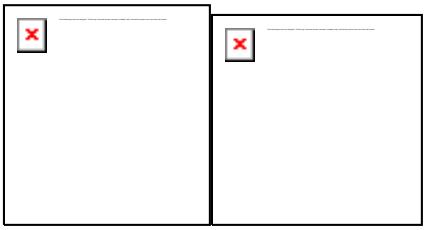

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Trinity Health
Of New England

January 31, 2018

Carmen Cotto
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: **Docket Number: 15-32045-CON** Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health Of New England

Dear Ms. Cotto,

Trinity Health Of New England is in the process of filing extensions for FY 2017 990s and they are due by August 15, 2018. The information needed to finalize all the community benefit questions is not yet available; therefore, we are unable to respond to Stipulation #12 with complete FY 2017 information. FY 2016 is the latest complete set of information available at this time and therefore was used in the Stipulation #12 response submitted January 19, 2018.

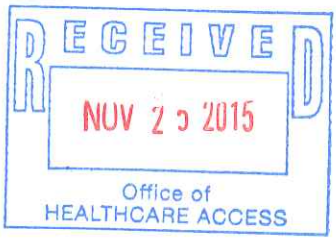
Please do not hesitate to contact me with any additional questions you may have.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

November 25, 2015

Via Hand Delivery



Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: CON Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc.

Dear Ms. Martone,

Enclosed please find the original CON application for the transfer of ownership and control from Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

We are pleased to be submitting this application to your office because it offers an outstanding opportunity for both entities to secure quality health care in the future for all of our patients. We anticipate that patients will have greater access to health care as we collaborate and share our resources. We also expect operational efficiencies in the new affiliated system that will benefit both entities by creating a secure financial base for the provision of health care in the future.

We look forward to any way that we may be useful in the process that lays ahead, and thank you, in advance, for your consideration of this application. If you have any questions, please do not hesitate to call any one of us.

Respectfully submitted,

Saint Mary's Health System, Inc.
and Saint Mary's Hospital, Inc.

By: _____
Chad W. Wable
President and CEO

Trinity Health – New England, Inc.

By: _____
Christopher M. Dadlez
President and CEO

Trinity Health

By: _____
D. Scott Nordlund
Executive V.P.

Checklist

Instructions:

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

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

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

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

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

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original in a 3-ring binder.

☒ The following have also been submitted on a CD or USB drive

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

For OHCA Use Only:

Docket No.: 15-32045-CON **Check No.:** 39410
OHCA Verified by: SO **Date:** 11/25/15

Customer	A/C #	Billing Period
ST. MARY'S HOSPITAL	75401	10/01/15-10/31/15

RepublicanAmerican

389 Meadow Street, Waterbury, CT 06722
Phone: 203-574-3636 Fax: 203-573-0090 Toll Free: 800-992-3232
E-mail: advbilling@rep-am.com

PAYMENT TERMS	30 DAYS
TOTAL AMOUNT DUE	$ 410.64

Fed EIN 06-0581760 * Please See Reverse Side for Pub Index

DATE	AD # / INV #	CUST ORDER #	PUB*	DESCRIPTION	SIZE	BILLED UNITS	TIMES RUN	RATE	BILLED AMOUNT
				PREVIOUS BALANCE					$0.00
10/22/15-10/24/15	RA0695501 / INV001055518		RA	NOTICE Under Connecticut General Statutes Sec. 19a-638,	1x	59.000	3	$2.3200	$410.64
				CURRENT AMOUNT DUE					$410.64
				TOTAL AMOUNT DUE					$410.64

NOTICE
Under Connecticut General Statutes Sec. 19a-638, as amended by Public Act 15-146 Saint Mary's Health System, Inc., a Connecticut non-stock corporation, and its affiliated entities, are proposing to join the Regional Health System created by Trinity Health Corporation, an Indiana nonprofit corporation, and Saint Francis Care, Inc., a Connecticut non-stock corporation. As a result of this proposed transaction, Saint Mary's Health System, Inc. including Saint Mary's Hospital, Inc. (Saint Mary's) will become a member of the new Regional Health System. The corporate organization and governance of Saint Mary's will be revised to be consistent with the organizational and governance structure of other New England Regional Health Ministry facilities. Saint Mary's Hospital, Inc. and all of its affiliates and related entities will remain at their current locations. There are no capital expenditures for this proposal. Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Saint Francis Care, Inc. and Trinity Health will file a Certificate of Need application for this project with the Department of Public Health through the Office of Health Care Access. The addresses of the organizations are as follows:

Saint Mary's Health System, Inc. and
Saint Mary's Hospital, Inc.
56 Franklin Street
Waterbury, CT 06706

Saint Francis Care, Inc.
114 Woodland St.
Hartford, CT 06105

Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152
RA 10/22,23,24,2015

RECEIVED
NOV 11 2015
CHAD WABLE

Past due balance accrues finance charge of 1.5% per month

All charges include any applicable Connecticut State sales tax

REMITTANCE ADVICE - PLEASE RETURN WITH PAYMENT	REMITTANCE ADDRESS	REPUBLICAN AMERICAN PO BOX 2090 WATERBURY, CT 06722-2090

CUSTOMER	A/C #	BILLING PERIOD	TOTAL AMOUNT DUE	AMOUNT REMITTED
ST. MARY'S HOSPITAL	75401	10/01/15-10/31/15	$ 410.64	

CREDIT CARD #	
EXPIRATION DATE	
SIGNATURE	

ST. MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY CT 06706

CHECK #	

RepublicanAmerican

389 Meadow Street • Waterbury, CT 06702 • 1-800-992-3232

Classified Advertising Proof

Account Number: 75401
Order Number: RA0695501

ann ferraro
ST. MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY, CT 06706
203-709-6000

Title: Republican-American | **Class:** L-Legal -Public Notice 019
Start date: 10/22/2015 | **Stop date:** 10/24/2015 |
Insertions: 3

Title: Rep-Am.com | **Class:** L-Legal -Public Notice 019
Start date: 10/22/2015 | **Stop date:** 10/24/2015 |
Insertions: 3

NOTICE

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Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152
RA 10/22,23,24, 2015

Total Order Price: $410.64

Please call or send an email by 3pm to approve or to make changes.
(No call back will result in your ad running as it appears on this proof.)

Advertisements placed on CTJobs.com, AfterCollege.com and Recruitment Networks run for 30 days

Salesperson: Deborah | **Printed on:** 10/21/2015
Telephone: 203-574-3636 ext 1162 | **Fax:** 203-754-0644

SAINT MARYS HOSPITAL
SMH RECEIVING DOCK 99 UNION STREET
WATERBURY, CT 06706

Vendor #16676
TREASURER STATE OF CT OAK ST WKRS CO

Nº 394110

P.O. NUMBER	INVOICE DATE	INVOICE NUMBER	INVOICE AMOUNT	DISCOUNT AMOUNT	NET AMOUNT
	11/20/2015	CON FILING	500.00	.00	500.00
		Totals:	500.00	.00	500.00

PAYMENT AMT: 500.00

Saint Mary's HOSPITAL

WEBSTER BANK - STMH - A/P
WATERBURY, CT 06706

Nº 394110

51-7010/2111

DATE
11/23/2015

CHECK AMOUNT
500.00

Five Hundred And 00/100 Dollars**********

PAY TO THE ORDER OF TREASURER STATE OF CONNECTICUT

TREASURER STATE OF CONNECTICUT
55 ELM ST
HARTFORD, CT 06106

TWO SIGNATURES REQUIRED IF OVER $50,000.00

Saint Mary's HOSPITAL

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Trinity Health – New England, Inc.
to become the Sole Member of Saint Mary's Hospital, Inc.
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State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- General Information
- Affidavit
- Abbreviated Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

All Supplemental Forms

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

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

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

General Information

Main Site*

MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
N/A	Inpatient – 004041760 Outpatient- 004025060	Hospital	Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

STREET & NUMBER	
56 Franklin Street	
TOWN	**ZIP CODE**
Waterbury, CT	06706

*For additional sites

Project Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
N/A	IP - OP-	Hospital	Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

56 Franklin Street	
TOWN	**ZIP CODE**
Waterbury, CT	06706

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)

STREET & NUMBER	
TOWN	**ZIP CODE**

Chief Executive

NAME	TITLE
Christopher Dadlez	President and CEO Trinity Health – New England, Inc.

STREET & NUMBER		
114 Woodland Street		
TOWN	STATE	ZIP CODE
Hartford	CT	06105

TELEPHONE	FAX	E-MAIL ADDRESS
860-714-5541	860-714-7920	cdadlez@stfranciscare.org

Title of Attachment:

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	See **Exhibit 10**

Does the Applicant have non-profit status? If yes, attach documentation.	YES ☒ NO ☐	See **Exhibit 23**
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☒	Other: _____
Applicant's Fiscal Year (mm/dd)	Start 10/01/14 End 09/30/15	

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

Contact Information			
NAME		TITLE	
R. Christopher Hartley		Senior Vice President Planning, Business Development & Government Relations, Trinity Health - New England, Inc.	
STREET & NUMBER			
114 Woodland Street			
TOWN		STATE	ZIP CODE
Hartford		CT	06105
TELEPHONE		FAX	E-MAIL ADDRESS
860-714-5573		860-714-8093	chartley@stfranciscare.org
RELATIONSHIP TO APPLICANT	Employee		

Contact Information			
NAME		TITLE	
Robert Anthony		General Counsel	
STREET & NUMBER			
56 Franklin Street			
TOWN		STATE	ZIP CODE
Waterbury		CT	06706
TELEPHONE		FAX	E-MAIL ADDRESS
203-709-6093		203-709-3238	BAnthony@Stmh.org
RELATIONSHIP TO APPLICANT	Attorney		

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

Prepared by			
NAME		TITLE	
Joseph Connolly		Chief Experience Officer and VP of Administration	
STREET & NUMBER			
56 Franklin Street			
TOWN		STATE	ZIP CODE
Waterbury		**CT**	**06706**
TELEPHONE		FAX	E-MAIL ADDRESS
203-709-6093		203-709-3238	jconnolly@stmh.org
RELATIONSHIP TO APPLICANT	Employee		

AFFIDAVIT

Applicant: **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **Chad Wable, President and Chief Executive Officer** of **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** being duly sworn, depose and state that **Saint Mary's Health System, Inc.** and **Saint Mary Hospital, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 11/23/15 Date

Subscribed and sworn to before me on 11/23/15

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

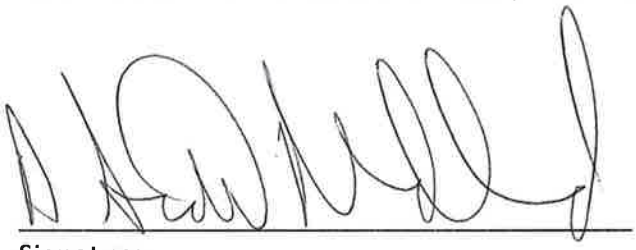
My commission expires: VICTORIA CIPRIANO NOTARY PUBLIC MY COMMISSION EXPIRES FEB. 28, 2017

AFFIDAVIT

Applicant: **Trinity Health**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **D. Scott Nordlund, Executive Vice President** of **Trinity Health** being duly sworn, depose and state that **Trinity Health's** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature

11·25·2015

Date

Subscribed and sworn to before me on 11-25-2015

Claudia A. Crane

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

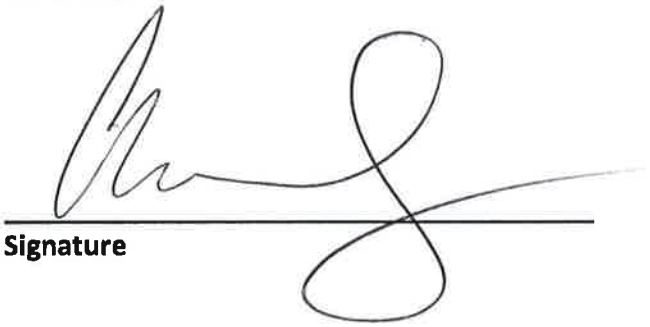
Claudia A. Crane, Notary Public
State of Michigan, County of Oakland,
My Commission Expires 11/17/2019
Acting in the County of _____

AFFIDAVIT

Applicant: **Trinity Health-New England, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, Christopher Dadlez, President and Chief Executive Officer of Trinity Health-New England, Inc., being duly sworn, depose and state that **Trinity Health-New England, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature 11-20-15 **Date**

Subscribed and sworn to before me on 11-20-15

Joseanne Christina Lubin-Scafuredi, Esq.

Notary Public/Commissioner of Superior Court

~~**My commission expires:**~~ _____

Executive Summary

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

If the proposed transaction described in this application is approved, Trinity Health-New England, Inc. (previously Saint Francis *Care*, Inc.), which, effective on October 1, 2015, became the new Trinity Health Regional Health Ministry (NE-RHM) will become the sole corporate member of Saint Mary's Hospital, Inc. (SMH) through a transfer agreement and the NE-RHM will serve as Saint Mary's Hospital parent. It is anticipated that Saint Mary's Health System will be dissolved, restructured or merged into Saint Mary's Hospital, Inc. (collectively referred to herein as "SMHS"). The key elements of this transaction include the following changes:

- Trinity Health, including the NE-RHM, is sponsored by Catholic Health Ministries, an entity established by the Catholic Church to oversee the healing ministry and Catholic identity of Trinity Health.
- SMHS and its related entities will join the NE-RHM in a manner consistent with other organizations within the NE-RHM. Please see **Exhibit 4** for the proposed NE-RHM organization chart. SMHS will continue to meet the service needs of its population within its defined primary service area.
- The proposed transaction is between not-for-profit entities. Although no cash purchase price is contemplated, if the proposed transaction is approved, Trinity Health through the NE-RHM will make substantial operational and financial commitments to SMHS and the communities it serves including:
  - Preservation and support of SMHS's not-for-profit mission and Catholic identity;
  - Commitment of at least $100 million dollars in capital investments to benefit SMHS and its related entities over a five-year period and an additional $20 million if certain performance metrics are achieved;
  - Access to NE-RHM and Trinity Health system services to reduce SMHS's operating costs and promote efficiency;
  - Development of a plan to adequately fund SMHS's pension liabilities; and
  - Improved access to capital and debt financing.
- The NE-RHM Board of Directors will include two members from the SMHS community that will be appointed to the NE-RHM.
- For three years following the effective date on which SMHS joins NE-RHM, in addition to any required external approvals, the existing SMHS Board must approve any terminations or material reduction of existing clinical services.
- To facilitate continuity of care in the SMHS service area, the medical staff admitting privileges and medical staff bylaws of SMHS and its related entities will remain in place.
- SMHS' medical education, research, community support and participation in governmental healthcare programs will not be changed as a result of this transaction.

- SMHS will remain a nonprofit, tax-exempt charitable organization and will honor all existing donor restrictions associated with philanthropic donations made to SMH and its related entities.

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

Project Description

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

The Parties

The parties involved are Saint Mary's Health System, Inc. ("SMHS"), including Saint Mary's Hospital, Inc., Trinity Health – New England, Inc. (previously Saint Francis *Care*), which effective October 1, 2015 joined Trinity Health and became the new Reginal Health Ministry in New England ("NE-RHM") and Trinity Health. All three entities operate as non-profit, 501(c)(3) corporations. As noted under The Proposal section below, it is anticipated that Saint Mary's Health System will be dissolved, restructured or merged with and into Saint Mary's Hospital.

Saint Mary's Health System, which includes Saint Mary's Hospital (Reference **Exhibit S1** for the current Saint Mary's Health System organization chart) is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community. NE-RHM is a regional provider of healthcare through Saint Francis Hospital and Medical Center and its numerous related facilities in the greater Hartford, Connecticut area. Trinity Health is a one of the largest national Catholic healthcare providers. This application is submitted to enable Saint Mary's Hospital and its related entities to join the NE-RHM.

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. (collectively referred to herein as "SMHS")

SMHS is a leading regional healthcare provider anchored by Saint Mary's Hospital (SMH), a Catholic, not-for-profit, acute care, community teaching hospital that has served Greater Waterbury since 1907. Licensed for 347 beds, SMH is designated as a Level II Trauma Center and operates one of the busiest emergency departments in the state. Its service area includes 16 towns and 2 boroughs in the greater Waterbury area. Its mission is to provide excellent healthcare in a spiritually enriched environment to improve the health of its community. SMH offers award-winning cardiac care and is the region's leading provider of surgical services. Surgical subspecialties include general, neurospine, orthopedics, cardiothoracic, breast, ear, nose and throat, eye, podiatry, urology, vascular and plastic surgery. SMH has established residency programs in internal medicine, surgery and general

dentistry with the Yale School of Medicine. SMHS has been recognized by the U.S. News & World Report as Top Performing in Heart Failure Care (2015); named a Top Performer by the Joint Commission two years in a row in the areas of heart attack, heart failure, pneumonia and surgical care; achieved seven Gold Awards from the American Heart Association/American College of Cardiology; one of the first hospitals to participate in the ACC's Patient Navigator Program to improve outcomes of heart failure patients; listed as one of the top 100 hospitals in value recognized by Cleverley & Associates three years in a row; and #1 hospital in Connecticut based on the CMS Value Based Purchasing Program. See **Exhibit 1** for SMHS's Awards and Accolades.

Trinity Health-New England, Inc. ("NE-RHM")

NE-RHM is the parent company of numerous health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford[1]. Saint Francis Hospital and Medical Center is the third largest hospital in Connecticut, and the largest Catholic hospital in New England. It is licensed for 617 general hospital beds and 65 bassinettes, and provides a full range of inpatient, outpatient and ancillary services. The service area includes Hartford and its surrounding towns. On August 31, 2015, NE-RHM received approval from the Office of Health Care Access in Docket No. 15-31979-CON to join Trinity Health. The transfer of NE-RHM to Trinity Health and the formation of a New England Regional Health Ministry became effective on October 1, 2015. If this application is approved, SMHS will be joining Trinity Health through NE-RHM, creating a formal partnership between two Connecticut Catholic health systems within a larger network of health systems and hospitals in New England.

Trinity Health

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 21 states from coast to coast with 88 hospitals, and 126 continuing care facilities, home health and hospice programs, and PACE center locations that provide more than 2.5 million visits annually.

The organization was formed in May 2013, when Trinity Health and Catholic Health East officially came together to strengthen their shared mission, increase excellence in care and advance transformative efforts with our unified voice. With annual operating revenues of about $15.8 billion and assets of about $20.4 billion, the new organization returns about $1 billion to its communities annually in the form of charity care and other community benefit programs.

Trinity Health employs more than 95,000 full-time employees, including 3,900 employed physicians. Committed to those who are poor and underserved in its communities, Trinity

1 NE-RHM is also the parent company of Mercy Hospital located in Springfield, Massachusetts.

Health is known for its focus on the country's aging population. As a single, unified ministry, the organization is the innovator of Senior Emergency Departments, the largest not-for-profit provider of home health care services — ranked by number of visits — in the nation, as well as the nation's leading provider of PACE (Program of All Inclusive Care for the Elderly) based on the number of available programs. Trinity Health is also focused on transitioning from success in the traditional fee for service based healthcare economy, to a people-centered population health organization. To ensure continued long-term sustainability while completing that transition, Trinity Health has developed and is implementing a strategic plan to enhance the scale and integration of the system in core markets.

Trinity Health has created an internal development team, charged with the growth and strategic positioning of the system. Two of Trinity Health's key growth initiatives aim to extend and strengthen the Catholic healthcare mission of the organization through alignment with other organizations, and to expand the system footprint to create an integrated accountable care organization ("ACO") in every one of its markets. The development team works with the executive management team and governance to identify growth priorities in acute care, outpatient, and population health areas to build out the continuum of service to achieve these goals. The development team takes a disciplined approach to structuring partnerships with identified organizations which have shared values and vision that help to accomplish key goals within markets.

Trinity Health has a breadth of experience in the use of best practices and quality data to improve service delivery. Dr. Richard Gilfillan, President and CEO of Trinity Health, currently chairs the Health Care Transformation Task Force, a group of providers, payers, purchasers and patient groups dedicated to the alignment of private and public sector efforts to advance value-based purchasing. Please refer to **Exhibit 2** for a list of members of this task force. The purpose of this group is to forge a common perspective and set of recommendations on different policy approaches that encourage sharing best practices from both clinical and financial perspectives and that change the way health care providers deliver and are reimbursed for care delivery. Through such sharing, the Health Care Transformation Task Force will help the country move toward a system focused on delivering quality care at a reduced cost. The chances of success of this value-based payment initiative are also reinforced by the track record Dr. Gilfillan has earned through his leadership of the Federal Center for Medicare and Medicaid Innovation, which oversaw the creation of accountable care organizations and bundled payments for Medicare.

The Proposal

The proposal is an organizational change request to allow Saint Mary' Hospital and related entities to become a part of NE-RHM. This will be effectuated by a Transfer Agreement (**Exhibit 3**) between Saint Mary's Health System, Inc., (which includes Saint Mary's Hospital, Inc.), Trinity Health-New England, Inc. (also known as NE-RHM) and Trinity Health (collectively "the Parties"). The NE-RHM will become the sole corporate member of Saint Mary's Hospital and Saint Mary's Hospital will be a direct subsidiary of NE-RHM. It is

anticipated that Saint Mary's Health System will be dissolved, restructured or merged with and into Saint Mary's Hospital. The proposed corporate structure is set forth in **Exhibit 4**.

There is no change in clinical services requested, nor is there any change of location involved with any of the clinical services now being offered by SMHS as a direct result of this proposal. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

All assets of SMHS will remain assets and properties of SMHS. All charitable gifts to SMHS will remain a part of Saint Mary's Hospital Foundation (a separate 501c3 organization) and will be used as the donor directed.

Trinity Health and NE-RHM have agreed to ensure the expenditure of One Hundred Million Dollars ($100,000,000) for capital expenditures at SMHS over the first five years following the effective date of the Transaction. If SMHS reaches a specified operating cash flow margin in the 3rd year following the effective date of the Transfer Agreement, an additional ten million ($10,000,000) dollars of committed capital will be available to SMHS in the 4th year following the effective date and similarly if in the 4th year following the effective date of the Transfer Agreement, SMHS reaches a specified operating cash flow margin, an additional ten million ($10,000,000) dollars of committed capital will be available to SMHS in the 5th year following the effective date. This committed capital will be available to support the capital needs of SMHS and its related entities, including strategic growth and infrastructure development for SMHS's integrated delivery system, to expand and upgrade SMHS's health care facilities, equipment and services provided by SMHS, and to support SMHS community health/population management initiatives as well as strategic growth, which includes physician network development.

Two members of the NE-RHM Board of Directors will be appointed by Trinity Health for a period of three years, with eligibility for re-appointment. These members will be from the SMHS community. Chad Wable will continue to serve as the President and CEO of SMHS and will also have a substantial and meaningful regional oversight/governing role in NE-RHM. SMHS will continue its Catholic identity and will operate in a manner consistent with the Ethical and Religious Directives for Health Care Services as promulgated by the United States Conference of Catholic Bishops.

As a result of this Transfer Agreement, the Parties intend to:

- improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area, including SMHS's Waterbury service area;

- enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to safety and satisfaction;

- reduce the costs of healthcare in the NE-RHM Service Area, including SMHS's

Waterbury service area;

- support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

Equipment/Service Locations and the Geographic Area the Proposal Will Serve

This proposal does not involve any new equipment, nor does it involve a change of location for any of the services currently being offered by SMHS or its related entities. For current locations of the health services that are provided by SMHS, please see the answer to Question No. 8, below. Similarly, the NE-RHM will not be adding or deleting services or any equipment as a result of this CON application, and its geographic area will not change as a result of this CON application. For the specific details of the current service locations and geographic area served by NE-RHM, please see OHCA Docket No. 15-31979.

Need for the Proposal in the Community

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. SMHS's motto is "Exceptional care. Every day. Every Patient." In order to maintain this high standard in the future, SMHS recognized a number of years ago that it would need to partner with another healthcare provider in order to maintain the quality it currently provides. This need to partner with another health care institution is driven by many factors. Changes in health care delivery, which became part of federal law with the passage of the 2010 Patient Protection and Affordable Care Act ("PPACA"), as well as reform in federal health policy and reimbursement have been a catalyst in propelling SMHS to seek new models of providing care. Other factors that have been intensifying and are contributing to the need for this proposal include:

- the increased cost associated with quality improvements,
- physician partnerships,
- clinical service redesign,
- electronic medical records development,
- strategic alignments to form an integrated organization,
- an aging infrastructure and the need to provide the health services the community in Waterbury requires, as reflected in the Community Needs Assessment (**Exhibit 6**).

There is also a need, along with the subsequent cost, to upgrade medical records to the standard required as a result of the PPACA. Furthermore, the range of services health care providers are required to offer has shifted from services healing the sick and injured to a focus on preventing illness and promoting wellness. At the same time that these external pressures have emerged, the population in Waterbury is rising, and the median age of the population is older than the State average (44 vs. 40). An older population utilizes more health services, in general, than a younger population. See answer to Question 8(a), Table

1, below.

The new healthcare technologies that have emerged in the last ten years, along with the high price tag of implementing some of this technology, have stretched the budgets of all health care systems, including SMHS. The sheer number of patients needing to be included in the system of electronic medical records has soared, and with it, the cost. The physical plant which houses Saint Mary's Hospital was built in 1907, and exceeds 1 million square feet. While renovations and remodeling have occurred over the years, as well as newer additions, the physical plant is in need of upgrades in order to continue providing exceptional care, as well as to accommodate the technology used for today's best practice medicine.

In anticipation of the many changes in the healthcare industry resulting from the passage of the PPACA, SMHS undertook a revision of their strategic planning process to create a vision and foundation for success for SMHS in the healthcare system of the future, a system that would be fundamentally different from the fee for service approach to healthcare delivery. The plan is continuously upgraded to match current goals. The 2016-2020 Strategic Plan is attached as **Exhibit 5**. The shift in emphasis from fee for service to accountable care organizations and population health means revamping the way health care is delivered. The emphasis on wellness means a shift in emphasis from inpatient hospital care to care that can be delivered in an outpatient setting, and a different set of objectives. The resulting strategy is directly related to the Community Needs Assessment (attached as **Exhibit 6)**, developed in collaboration with a number of local providers and stakeholders and published in September of 2013 which identified the major health needs of the Waterbury community.

In order to achieve all of these goals, SMHS needs a stronger financial base. It has a responsibility to fund its employee pension plan and ensure access to capital in order to invest in the shift to a new way of delivering health care.

While strategically positioning itself for the challenges and opportunities posed by the Affordable Care Act and other changes in the healthcare industry, SMHS, like many other healthcare systems, determined that its mission and goals could best be effectuated by partnering with another healthcare system with a complementary mission and similar goals. SMHS recognized many years ago that it would be prudent to become partners with another hospital or health care system in order to take advantage of the strength that would result from consolidation. Sharing clinical expertise, best practice management, and the value that can be derived from joint purchasing in larger volume led SMHS to continually look for a partner that would match SMHS commitment to providing quality care to all the people in its service area, while being compatible with its Catholic tradition and principles. Over the last ten years, SMHS actively looked for another hospital to be its partner. But healthcare changed dramatically in the past few years. During the last year, SMHS contemplated joining a regional/national health system in order to help SMHS achieve a successful implementation of its Strategic Plan. In the creation of the new regional health ministry, SMHS found that Trinity Health and NE-RHM had a strategic plan

very similar to its own, and Trinity Health has the experience to help both Connecticut systems to achieve their goals. NE-RHM and Trinity Health are more closely aligned with SMHS than any previous potential partner. They all share a common vision, similar values, philosophy and mission, and together will strengthen the Catholic healthcare tradition in the NE-RHM service area. To achieve its vision of Best*Care* for a Lifetime, NE-RHM has already begun its transformation to a virtually integrated care delivery network that provides care through a combination of aligned providers, which has been developed through both alliances and select acquisitions. To further its transformation to an integrated delivery system, NE-RHM has redesigned its organizational structure into a strategic portfolio composed of service lines and support platforms, all of which serve as conduits for the delivery of care across the system. (Please see **Exhibit 7** for an outline of NE-RHM service lines and support platforms.) The focus of this structure and these aligned providers is to meet the Affordable Care Act Triple Aim objectives of improving population health, enhancing the patient care experience and controlling costs while maintaining a positive financial margin. This transformation will facilitate the transition by NE-RHM from a provider of clinical services to a manager of the health of populations.

Christopher M. Dadlez, FACHE, the President and CEO of Trinity Health-New England, Inc., which will be the parent of Saint Mary's, recently published an article entitled, "Population Health Management: The Intersection of Concept and Reality" that further articulates the future of healthcare and the movement of NE-RHM towards population management (see **Exhibit 14**). As Mr. Dadlez notes, population management will be achieved through a clinically integrated network of alliances, aligning primary, secondary and tertiary services with community hospitals to promote the delivery of "the right care in the right place for the right value." NE-RHM also will leverage its support platforms to achieve economies of scale where possible to lower the overall cost of care to the community (see **Exhibit 8**). This mirrors SMHS's goal of exceptional care, for every patient, every day, while lowering the cost of that care.

The benefits to SMHS's from this partnership with NE-RHM and Trinity Health are as follows:

- To have access to the resources of a large system at both the regional (NE-RHM) and national (Trinity Health) levels which will allow SMHS to continue to provide quality health care services in the greater Waterbury area and be able to expand those services within its service area by making them more accessible to a greater number of people;
- To have the resources necessary to help develop more preventive and primary care services in the greater Waterbury area so that patients in the SMHS's service area stay healthy, including the resources to implement the programs identified in the 2014 Community Health Needs Assessment;
- To meet the demands of the 2010 Patient Protection and Affordable Care Act which requires an emphasis on value rather than volume in terms of reimbursement for health care services;

- To create efficiencies so that health resources are not wasted, which will also enable more patients to be served;
- To have readily available access to capital and financing for that capital at favorable interest rates; and
- To develop a plan to adequately fund SMHS's pension plan obligations.

Trinity Health-New England, Inc. ("NE-RHM")

NE-RHM set forth the reasons for joining Trinity Health in its CON application located in Office of Health Care Access Docket No. 15-31979-CON. The reasons Trinity Health – New England, Inc. sought to partner with Trinity Health are very similar to the reasoning of SMHS.

NE-RHM*'s* Board leadership created a special ad hoc Advisory Committee to review potential partners that would enable NE-RHM to meet the strategic goals outlined in their CON application. A number of potential strategic partners were considered before NE-RHM selected Trinity Health.

NE-RHM determined that Trinity Health was the ideal affiliation partner in that it satisfies the strategic, mission, financial and governance goals established by NE-RHM as part of its selection process. More particularly, Trinity Health enhances NE-RHM's ability to fulfill its strategic vision in that:

- Trinity Health is one of the largest Catholic health systems in the country and an organization that has a mission and strategic vision essentially identical to those of NE-RHM;
- The transaction preserved and supported NE-RHM*'s* not-for-profit status, mission, values and Catholic identity;
- Access to Trinity Health system services provides operational efficiencies for NE-RHM;
- Access to national best practices and expertise enhances NE-RHM, ability to pursue existing and future programs related to population health, emerging models and initiatives for the delivery of healthcare, and health information technology;
- Trinity Health is a national system with a AA- credit rating which grants NE-RHM access to capital and provides an opportunity to lower NE-RHM, cost of debt financing; and
- Trinity Health agreed to (i) develop a plan to enable NE-RHM to satisfy long-term pension liabilities, and (ii) provide commitments for capital which will ensure investments of at least $275 million over the next five years.
- Trinity Health is committed to maintaining a local and regional presence.

The result of this evaluation was a decision by NE-RHM to file a CON application with the Office of Health Care Access to become part of the Trinity Health Care system. The transfer of NE-RHM to Trinity Health created the new Trinity Health – New England, Inc. ("NE-

RHM"). (See OHCA approval of Docket Number 15-31979 CON on 8/31/15). The new organization is continuing its pursuit of other like-minded health system partners to add to its regional ministry. As a part of this pursuit, the NE-RHM responded to a Request for Proposal from SMHS.

If this proposed transaction is approved, SMHS will serve as an important part of this regional health ministry. The addition of SMHS to the NE-RHM will enhance its ability to pursue local partnerships and affiliations across the continuum of care, evaluate additional acute care growth opportunities across the region, and work to develop broader population health and risk-bearing capabilities appropriate to the evolving healthcare markets.

The proposed transaction will facilitate the continuation of SMHS's 108+ year commitment to providing health care services to patients in the communities it serves in the dynamic and changing environment of health care delivery. SMHS will build on this foundation and its own long-standing commitment to quality and clinical excellence. The NE-RHM is well recognized for its commitment to quality care as evidenced by the extensive list of awards and recognitions. (See **Exhibit 9**). The Waterbury community served by SMHS will benefit greatly from this proposal.

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

In February 2015 SMHS hired Hanlon, Hammond Camp, LLC ("H2C") as its consultant to guide them on the affiliation process. H2C reached out to a select group of not-for-profit hospitals that had or would likely soon have a presence in the Connecticut market. In early March 2015, H2C sent confidentiality agreements and a transmittal letter/term sheet to three organizations. The organizations included Trinity Health and two Connecticut hospital networks. By late March, all of the organizations executed the confidentiality agreement and responded with either a proposal or a revised term sheet. Another hospital system (#4) reached out to H2C and expressed interest in SMHS. A confidentiality agreement was executed and a transmittal letter was sent to them in late March 2015. However, in early April 2015, Hospital System #4 withdrew from the process. All three remaining proposals were strong and competitive.

Trinity Health and NE-RHM met with the SMHS's Board-appointed Taskforce ("the Taskforce") on March 24, 2015. In late April and early May 2015, the Taskforce met with the three original potential partners. In late May 2015, several SMHS Taskforce members conducted a site visit to Mercy Medical Center in Springfield, Massachusetts, which is affiliated with Trinity Health.

In early June 2015, one of the Connecticut hospital networks (#3) was eliminated from consideration for a full member substitution due to their inability to fully meet the guiding principles for the Ethical and Religious Directives ("ERD"). The SMHS Taskforce remained very interested in clinical affiliations and other possible partnerships models with Trinity Health and NE-RHM.

In June 2015, a group of physician leaders from SMHS met with physician leaders from the second Connecticut Health Network (#2). A similar meeting was held with NE-RHM and Trinity Health physician leaders.

Throughout June 2015, H2C continued discussions with Connecticut Health Network (#2) and Trinity Health and NE-RHM (#1). By early July Trinity Health, NE-RHM and SMHS discussions were moving forward, and in mid-July, due diligence began and SMHS opened up the full data room to Trinity Health and NE-RHM, and commenced a 30-day exclusivity period with Trinity Health and NE-RHM. H2C presented the SMHS Board with a high level comparison of offers. The SMHS Taskforce and Board had access to the following documents for Trinity Health and NE-RHM.

- A Taskforce Issues List was created with Trinity and the other potential partner, (Health Network #2) where the two entities were compared on the following topics: Strategic, Pension, Financial, Canonical/ERDs, Capital Expenditures, Governance Rights, Medical Community, Clinically Integrated Network/Population Health, Physician Recruitment/Talent, Reverse Due Diligence, Transactional Risks, Mission/Cultural Fit and Clinical Capabilities. A second detailed Comparison of Offers was created.

- Additional information on a number of hospitals in Connecticut was prepared for purposes of comparison, including the status of pension funds of the entities being considered as a partner.

- Based on the recommendation of the SMHS Board Taskforce, the full board voted on September 13, 2015 to approve a Transfer Agreement with Trinity Health and NE-RHM to become part of the Trinity New England Regional Health Ministry. On September 18, 2015 the three parties signed the Transfer Agreement.

A significant difference between Trinity Health and NE-RHM and Connecticut Hospital Network #2 is that SMHS's pension plan would remain a church plan in Trinity Health's network. In Network #2, SMHS's pension plan would become an ERISA plan, which required additional logistical and administrative costs. Trinity Health also has a broader network of clinical services than Network #2, and can offer more technical expertise than all of the other proposals that were considered. As a national Catholic healthcare network, Trinity Health's mission and values were more closely aligned with SMHS's than the other networks. After evaluating the proposals, the Taskforce recommended continuing discussions with Trinity Health and NE-RHM.

The SMHS Board of Directors meeting minutes documenting the vote are included. (See **Exhibit 10**).

3. Provide the following information:

a. utilizing OHCA Table 1, list all services to be added, terminated or modified, their

physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

No changes in existing services are included in this Certificate of Need Application. Hence, this table is not applicable.

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

Please refer to **Exhibit 11.** Also refer to the answer to the question 8(a) below, including Figure 1.

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

No new licenses are being sought in this CON application.

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

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

Please refer to **Exhibit 12** for a copy of all the existing Department of Public Health licenses.

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

SMHS:
Chad Wable, FACHE President and Chief Executive Officer
Ralph W. Becker, MBA Vice President & Chief Financial Officer
Charles Flinn, FACHE, Vice President & Chief Operating Officer

Trinity Health - New England, Inc.:
Christopher Dadlez, FACHE, President and Chief Executive Officer
John Rodis, M.D., Chief Operating Officer
David Bittner, Chief Financial Officer

Trinity Health
Richard J. Gilfillan, M.D., MBA, President and Chief Executive Officer
Benjamin R. Carter, CPA, FHFMA, Executive Vice President and Chief Financial Officer/Treasurer
James Richard O'Connell, Executive Vice President – East Group
D. Scott Nordlund, Executive Vice President

Please refer to **Exhibit 13** for copy of all the Curricula Vita related to this project.

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

This question is not applicable as this CON is not requesting new services. However, attached are two relevant articles pertaining to organizational change.

Exhibit 14a: Dadlez, Christopher. "Population Health Management: The Intersection of Concept and Reality", Frontiers of Health Services Management 30:4
Exhibit 14b: Gilfillan, MD, Richard J. "Today's Transformation Mission-Opportunity Abounds to Bring More People Better Care", Catholic Health Association of the United States; September-October 2015.

d. letters of support for the proposal;

See **Exhibit 15** for letters of support received to date for this Certificate of Need.

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

This question is not applicable since this Certificate of Need is an organizational change request not a change in clinical services.

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

Please refer to **Exhibit 3** for a copy of the Transfer Agreement and other documents related to this proposed organizational change.

Public Need and Access to Care

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

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

The proposed project is consistent with all existing policies and standards in regulations

adopted by the Connecticut Department of Public Health. All of the existing hospitals involved in this CON application as well as their affiliated health care providers are in compliance with existing laws. As a result of this application, the existing health services now offered by SMHS, either at the hospital or off-site will not change.

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

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

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

The Transfer Agreement between SMHS, NE-RHM and Trinity Health is consistent with the *Statewide Health Care Facilities and Services Plan* (the "Plan") published by the Connecticut Department of Public Health's Office of Health Care Access ("OHCA") in October of 2012 and supplemented in 2014. The Transfer Agreement between the three parties is clearly aligned with the premise of the Plan. Section 1.4 of the Guiding Principles of the Plan states:

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;

- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state. (Plan at, p. 2.)

As the Plan makes clear, as of 2012, OHCA was aware that mergers, affiliations and acquisitions were part of a transformation that had begun as the State's health care system responded to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5) By 2014, the supplement to the Plan listed the corporate affiliations that have already occurred in Connecticut. Becoming part of a larger health care system such as Trinity Health will aid SMHS in developing economies of scale when purchasing supplies and services, and will also improve access to capital. These factors, in turn will allow SMHS to improve the quality of care that is required by the 2010 Patient Protection and Affordable Care Act ("PPACA").

As OHCA has recognized in the Plan, the strategic, financial and quality of care advantages associated with the affiliation or mergers of hospitals and health care providers are key drivers in today's health care environment. Connecticut hospitals are pursuing affiliation arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow SMHS to make needed capital improvements, invest in new technology and continue to be a safety net provider in the Greater Waterbury region.

By entering into the proposed Transfer Agreement with Trinity Health, SMHS and the NE-RHM will be able to work actively towards expanding cost control initiatives in community-based settings and remain a lower-cost, high-quality provider for the patients in its service area.

As part of the NE-RHM, SMHS will be able to improve its technology and the overall standard of care for its patients. The Plan recognizes that a health information technology exchange ("HITE") "makes it possible for health care providers to better manage patient care through secure use and sharing of health information." (Plan at p. 14, Sec. 2.2.1). The NE-RHM will provide access to capital and the Trinity Health intercompany loan program, if necessary, to develop a HITE and electronic health records ("EHRs"). Paper records will be replaced by EHRs to report patients' diagnostic data. Opportunities to regionalize the health care delivery system in the greater Waterbury area will be enhanced, building upon existing initiatives. The size of Trinity Health and the NE-RHM will provide SMHS with regional and national scale, leverage and resources to meet the health care reform requirements of the PPACA.

The PPACA requires hospitals to improve quality of care delivered to patients through a variety of means such as improving infection control programs and reducing preventable readmissions for certain conditions. (Plan at pp. 12-13, Sec. 2.1.2, 2.1.3, 2.1.4., 2.1.4.2 and 2.1.4.3). Trinity Health, as a national provider of health care, is aware of these requirements and has the ability to share best practices among its member hospitals, and has already provided evidence at its existing facilities of improving infection control programs and reducing readmissions. This proposal promotes Population Health Management which is a system that emphasizes health promotion and the delivery of preventive and medically necessary care. Population Health Management promotes collaboration among providers and the development of a continuum of care where providers are more closely aligned and work in a cohesive environment. Trinity Health has experience with 88 hospitals and provides an environment that SMHS's physicians and other providers across the continuum of care can utilize to provide access to evidence-based practices. These practices will improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

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

a. identify the target patient population to be served;

SMHS has a service area that consists of 16 towns and two boroughs. The primary service area ("PSA") consists of Naugatuck, Prospect, Waterbury and Wolcott. The secondary service area ("SSA") includes the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plymouth, Southbury, Southington, Thomaston, Watertown and Woodbury. The two boroughs in the secondary service area are Terryville (part of Plymouth) and Plantsville (part of Southington). Please see Figure 1 for a map of the service area. The 16 towns and 2 boroughs have historically been the towns SMHS has included in its service area. These towns accounted for 93.5% of the Hospital's volume in FY2015.

Figure 1: Saint Mary's Health System, Inc. Service Area

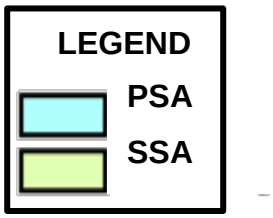


Table 1 provides a summary of the population of the service area from 2000 projected to 2020. The City of Waterbury (a PSA for the Hospital) is projected to experience a 4.9% increase in population from 2010 to 2020. A population increase of 5.5% is projected for the 12 town secondary service area. (See **Table 1** below.)

Waterbury is the largest municipality in the service area. In 2010, it accounted for 66% of the population in the primary service area and 32% of the population in the total service area.

Table 1: Total Population 2000 – 2020

Town	2000	2010	2020
Naugatuck	30,989	31,746	32,877
Prospect	8,707	9,282	9,864
Waterbury	107,271	109,941	115,128
Wolcott	15,215	16,446	17,821
Primary Service Area	**162,182**	**167,415**	**175,690**
Beacon Falls	5,246	5,909	6,648
Bethlehem	3,422	3,595	3,711
Cheshire	28,543	29,200	29,120
Middlebury	6,451	7,390	8,471
Morris	2,301	2,461	2,460
Oxford	9,821	12,192	14,714
Plymouth	11,634	12,213	12,789
Southbury	18,567	19,690	20,480
Southington	39,728	42,491	45,136
Thomaston	7,503	7,873	8,112
Watertown	21,661	22,522	23,020
Woodbury	9,198	9,909	10,395
Secondary Service Area	**164,075**	**175,445**	**185,056**
Total Service Area	**326,257**	**342,860**	**360,746**

Source: Connecticut Economic Resource Center, Inc. (CERC, 2014). Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

Tables 2 and 3 describe the age distribution in the primary and secondary service areas by town. The age distribution of the service areas is also compared to that of the state. SMHS's total service area has a median age of 44 compared to the state's median age of 40 (CERC, 2014). The difference in age is one of many contributing factors that lead to increased healthcare utilization.

Table 2: Age Distribution Primary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Naugatuck	6.3%	15.0%	8.4%	35.3%	21.5%	13.4%
Prospect	4.3%	16.5%	8.8%	32.7%	23.1%	14.5%
Waterbury	7.3%	18.0%	10.2%	34.4%	17.4%	12.6%
Wolcott	3.3%	19.3%	8.2%	32.2%	21.4%	15.7%
PSA	**6.6%**	**17.5%**	**9.6%**	**34.2%**	**18.9%**	**13.2%**
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC, 2014

Table 3: Age Distribution Secondary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Beacon Falls	5.3%	18.1%	7.7%	33.9%	22.8%	12.1%
Bethlehem	3.4%	15.2%	9.1%	22.9%	31.2%	18.1%
Cheshire	4.3%	19.1%	9.1%	32.3%	21.0%	14.2%
Middlebury	3.7%	18.8%	5.7%	30.5%	23.4%	17.8%
Morris	3.5%	18.5%	6.3%	31.5%	28.1%	12.2%
Oxford	5.9%	18.6%	7.0%	30.4%	25.4%	12.7%
Plymouth	4.6%	16.7%	9.0%	33.2%	23.7%	12.7%
Southbury	3.8%	17.3%	5.7%	23.3%	22.8%	27.1%
Southington	5.2%	16.9%	6.1%	32.0%	22.1%	17.7%
Thomaston	3.5%	16.1%	8.1%	36.6%	21.5%	14.2%
Watertown	5.2%	16.9%	7.6%	31.4%	22.3%	16.5%
Woodbury	4.0%	16.4%	6.4%	27.5%	29.0%	16.7%
SSA	4.6%	17.5%	7.2%	30.7%	23.1%	16.9%
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC, 2014. Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

Table 4 presents socio-economic data for the primary and secondary service area in comparison to the State. The data for the total service area reveals a diverse population ranging from urban to suburban to rural. While some of the communities are composed of an older, more affluent population, Waterbury is an economically distressed community with 20% of its population below the poverty level. The significant levels of poverty are reflected in the patient mix treated at the Hospital. In Fiscal Year 2015 Year to Date (October 1, 2013 – June 30, 2015), 43.9% of patients discharged from the Hospital were Medicaid recipients.

Central Waterbury has been designated by the Health Resources and Services Administration as a Health Professional Shortage Area as well as a Medically Underserved Area and Medically Underserved Population. The Hospital serves

as a safety net hospital to this region. This proposal provides the necessary cost savings opportunities to ensure that health care services will remain available to the vulnerable population in the Hospital's service area. The proposal will ensure a more secure financial future so that the Hospital can continue to provide essential health services to the community. It is premature to have completed detailed projections of operational savings, however, an annual savings of at least 1% of SMHS's revenues, or about $3M, are anticipated based on historical savings generated after acquisition by Trinity Health's. We would expect that approximately 50% of this savings will be realized within the first 12-15 months of the closing of the proposed transaction. In each future year, it is expected that the same $3M in cost savings resulting from the transaction will continue to impact favorably on SMHS as compared to its current operations.

Table 4: Socio/Economic Data

Town	Poverty Rate*	Household Income*	Unemployment rate**	Median Age*
Primary Service Area				
Naugatuck	8.6%	$62,574	9.4%	39
Prospect	3.2%	$95,325	6.7%	44
Waterbury	21.9%	$40,867	12.5%	35
Wolcott	3.4%	$80,655	7.8%	44
Secondary Service Area				
Beacon Falls	3.8%	$79,207	7.0%	39
Bethlehem	4.4%	$80,884	5.8%	50
Cheshire	2.8%	$110,587	6.2%	41
Middlebury	2.6%	$97,996	6.6%	44
Morris	5.6%	$89,688	5.9%	45
Oxford	4.5%	$107,308	6.4%	45
Plymouth	6.7%	$73,603	8.9%	41
Southbury	6.4%	$67,195	6.6%	50
Southington	3.6%	$78,668	6.4%	44
Thomaston	2.7%	$67,426,	7.8%	43
Watertown	3.4%	$80.899	7.7%	44
Woodbury	4.6%	$80,167	5.9%	48
Connecticut	**10.0%**	**$69,519**	**7.8%**	**40**

**2012*

*** 2013*

Source: CREC 2014. Oakville data is included with Watertown, Plantsville data is included with Southington and Terryville data is included with Plymouth.

After the CON proposal is implemented, the existing populations that the Hospital serves will continue to have access to the same services that SMHS

currently provides.

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

The Hospital provides a comprehensive range of services that meets the needs of its target population. The services are listed below:

Cardiovascular services

- Diagnostic catheterization
- Interventional Cardiology- Angioplasty
- Pacemaker Implantation
- Cardiac surgery
- Medical Cardiology
- Telemetry Monitoring
- Cardiovascular unit for post interventional patients
- Electrophysiology

Surgical services

- General surgery
- Robotic surgery
- Bariatric surgery
- Neurosurgery
- Orthopedic surgery
- Other surgical specialties including colorectal, gynecology, urology, gastroenterology, otolaryngology, podiatry, thoracic, vascular, breast and oncology
- Ambulatory surgery (on hospital main campus as well as off-site at Naugatuck Valley Surgical Center)

Medical services

- General Adult Medicine
- Pulmonary
- Neurology
- Oncology/Hematology
- Endocrinology
- Critical Care Medicine
- Other medical specialties covering nephrology, gynecology, urology, gastroenterology, rheumatology

Women and Infant services

- Obstetrics
- Neonatology (Level 2 NICU)

Behavioral Health

- Adult and adolescent inpatient Behavioral Health services
- Outpatient Mental Health Clinic and Substance Abuse Treatment Center

Emergency Department

- Emergency Department including a Level 2 Trauma Center
- Designated a Primary Stroke Center (by Connecticut Department of Public Health)

Imaging Services

- CT Scanning
- Digital mammography
- DEXA bone density scanning
- Nuclear Medicine
- Ultrasound
- MRI
- X-ray
- PET/CT (through the Harold Leever Regional Cancer Center)

Interventional Radiology

- Angiography
- Biopsies
- Stent Placement

Breast Care

- Stereotactic breast biopsies
- Breast ultrasound

Other Outpatient Programs

- Three Urgent Care Centers located in Naugatuck, Waterbury and Wolcott
- Accredited Sleep Disorders Center located in Wolcott and Waterbury
- Physical and Occupational Therapy
- Cardiac and Pulmonary Rehabilitation
- Pulmonary Function Testing
- Endoscopy Services
- Dental Clinic
- Family Health Center
- Cardiac Diagnostic Testing
    - Nuclear Stress Testing
    - Echocardiography
    - EKG
    - Holter monitoring/event and loop recording
- Laboratory Services

Services are provided on the Hospital's main campus as well as outpatient locations throughout the service area.

SMHS currently leases space on the main campus to two organizations to provide inpatient services. Inpatient pediatric services are provided by

Connecticut Children's Medical Center ("CCMC") and inpatient hospice services are provided by VITAS, a national provider of hospice and palliative care.

Saint Mary's Physician Partners, LLC (an Accountable Care Organization) is a clinically integrated physician network that provides services to beneficiaries of certain insurance programs and facilitates the coordination and cooperation among healthcare providers to improve quality.

The Hospital offers health care services under its license at the following locations:

- Naugatuck Valley Surgical Center, 160 Robbins St., Waterbury;
- Naugatuck Urgent Care Center, 799 New Haven Rd., Naugatuck;
- Wolcott Urgent Care Center, 503 Wolcott Rd., Wolcott;
- West Main Urgent Care Center, 1312 West Main St., Waterbury;
- Cardiovascular Diagnostic Center, 1320 West Main St., Waterbury;
- Occupational Health & Diagnostic Center, 1312 West Main St., Waterbury;
- Saint Mary's Outpatient Center, 1981 East Main St., Waterbury;
- Saint Mary's Outpatient Behavioral Health Services, 100 Jefferson Sq., Waterbury;
- Saint Mary's Blood Draws:
    1) 133 Scovill St., Waterbury;
    2) 1981 East Main St., Waterbury;
    3) Union Square, Southbury; and
    4) 70 Hemingway Park Rd., Waterbury.

- Franklin Medical Group, P.C., a physician group of approximately 88 physicians and 46 midlevel providers have 17 office locations in the Greater Waterbury area including:
    1) 133 Scovill St., Waterbury; Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary;
    2) 95 Scovill St., Waterbury; Specialties: Internal Medicine and Pediatrics,
    3) FMG Behavioral Healthcare Outpatient Services; 100 Jefferson Square, Waterbury; Specialty: Outpatient Behavioral Health Services;
    4) 1981 East Main St., Waterbury; Specialty: Internal Medicine;
    5) 202 Water St., Naugatuck; Specialty: Internal Medicine;
    6) FMG Primary Care Partners, 166 Waterbury Rd., Prospect; Specialties: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery and Breast Surgery;
    7) FMG Wolcott Internal Medicine, 503 Wolcott Rd., First Floor, Wolcott; Specialty: Internal Medicine;
    8) FMG Breast and Oncology Center, 33 Bullet Hill Rd., Suite 214, Southbury; Specialties: General Surgery and Breast Surgery;
    9) 1320 West Main St., Waterbury; Specialties: Cardiology, Pulmonary (Sleep Medicine);

10) 140 Grandview Ave., Suite 4, Waterbury; Specialty: Gastroenterology;
11) 590 Middlebury Rd., Suite A, Middlebury; Specialty: General Surgery;
12) 1389 West Main St., Waterbury; Specialty: General Surgery;
13) 70 Heminway Park Rd., Watertown; Specialty: Internal Medicine; and
14) 56 Franklin St., 2nd Floor, Waterbury; Specialty: Cardiology.
15) Digestive Disease Center of CT; 60 Westwood Avenue, Waterbury, CT 06708
16) Naugatuck Internal Medicine; 1177 New Heaven Road, Naugatuck, CT 06770
17) Polokoff Breast Care; 900 Main Street South, Southbury, CT 06488

- Radiology services are offered at Diagnostic Imaging of Southbury, LLC, 385 Main St., Southbury;
- Cancer Services are offered at the Harold Leever Regional Cancer Center, 1075 Chase Pkwy. Waterbury. This facility, owned 50% by Saint Mary's Hospital and 50% by Waterbury Hospital.
- Heart services are offered under the auspices of the Heart Center of Greater Waterbury, Inc., 1075 Chase Pkwy., Waterbury; and are provided at Saint Mary's Hospital and Waterbury Hospital. This entity, owned 50% by each hospital, is not part of this CON application.
- Diagnostic services are offered at Naugatuck Valley MRI, LLC in 4 locations within the service area.

All health care services, including those provided by CCMC and VITAS, will continue to be offered at their current locations.

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

This question is not applicable. Changes to services or equipment are not included in this proposal.

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

There are no new locations in this CON proposal. SMHS is located in Waterbury.

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

Please see response to Question 8.a., above.

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

SMHS Catholic mission is to serve all patients regardless of race, ethnicity, handicap, religion, income level, or ability to pay. This will not change if the CON

proposal is approved. For additional information please see response to Supplemental CON Application Form, Transfer of Ownership/Sale of Hospital, Question 4.j.

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

No immediate changes to the clinical services provided by SMHS are planned at this time as a direct result of this proposal. The NE-RHM will provide additional support for continuing quality improvement of the clinical services provided at SMHS, and at this time no changes in clinical services are being proposed. Going forward, if this proposal is approved, as proposed changes are identified, the NE-RHM will comply with the Certificate of Need laws and will file the appropriate documents with, and seek the approval of, the Office of Health Care Access as required by law.

h. explain how access to care will be affected;

This Certificate of Need Application is to sustain and strengthen the services at SMHS ensuring that access to services is not only maintained, but expanded in order to meet evolving community need. Reduction of services is not part of this proposal. Also, please refer to response to 9a below.

i. discuss any alternative proposals that were considered.

Please refer to Question 2.

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

9. Describe how the proposal will:

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

SMHS will have access to the NE-RHM's experts in all clinical service lines and support platforms, and its service delivery approach and systems will be enhanced with the goal that programming at SMHS mirror the performance of like programs at NE-RHM. Particular focus will be on the Cancer, Joint Replacement and Cardiology service lines.

In order to improve the quality of health care services in the Waterbury service area, and to contribute to the future of outstanding health care in general, SMHS

offers graduate medical education programs in:

- Internal Medicine Residency
- Dental Residency
- General Residency
- Yale Medicine – Pediatrics Residency

SMHS has been affiliated with the Yale University School of Medicine for over 40 years. Nearly all of SMHS faculty are Yale faculty members. SMHS has produced physicians of the highest caliber, including academic and clinical general internists, medical subspecialists, and both clinical and laboratory investigators.

The Internal Medicine Residency includes rotations in Cardiology, ICU, Night Float, Ambulatory, Elective, Emergency Dept., General Wards and the Family Health Center. The chairman of the Department of Medicine at SMHS and Program Director of the Internal Medicine Residency Program is Jason R. Ouellette, MD, FACP. Dr. Ouellette is also an Assistant Clinical professor at Yale University School of Medicine.

The Dental Residency Program involves a one-year General Practice Residency (GPR) which has been fully accredited by the American Dental Association since 1951. SMHS also participates in the Dental Postdoctoral Application Support Service (PASS) which is one of only five such programs in Connecticut, offering participants a wide range of clinical experience.

The general Surgery Residency Program is an independent training program, graduating two Chief residents per year. Dr. J. Alexander Palesty, MD, FACS is the Program Director while Dr. Philip Corvo, MD, FACS is the Chairman of the Stanley J. Dudrick Department of Surgery. The training program in surgery is a 6-year program. Residents are exposed to pre-operative, operative as well as post-operative and non-operative care of patients in all of the components of general surgery.

SMHS is one of the four hospital teaching sites which hosts the Yale Medicine/Pediatrics Residency Program. Combined with the other three residency programs offered with Yale, SMHS has established its commitment to quality health care through the education of our future physicians.

In addition, whenever possible, SMHS's physicians and staff will be involved in the educational and health care innovation efforts of the NE-RHM. The following are examples of the educational and health care innovations efforts of NE-RHM that present opportunities for SMHS's physicians and staff:

- The NE-RHM also has a long standing commitment to the education of medical, dental, nursing and allied health professionals. This educational focus emphasizes quality and application of cutting edge technology to the treatment of patients. In addition, through its Institute for Primary Care

Innovation Simulation Studio, students, residents, fellows and current practicing physicians are exposed to the latest developments in health care delivery. The constant influx of bright, questioning minds encourages innovation and applications of the latest techniques. In addition, organizations that participate in the training of the next generation of providers provide better care and attract a higher caliber of providers. The NE-RHM's focus on population management and health outcomes is also regularly stressed as part of its various teaching endeavors.

- The NE-RHM sponsors medical, surgical, dental, nursing and allied health educational programs because it recognizes that education is fundamental to maintaining excellence in patient care and to ensuring the continued institutional development of new resources for the care of its patients. Continuing medical education activities are integrally related to undergraduate and graduate educational programs. Together, they have an important impact on the medical staff, promoting the delivery of medical care consistent with contemporary national standards and early introduction of new advances in medical and surgical care. The current availability of house staff at the NE-RHM plays an important role in the provision of high-quality care, and these individuals serve as an important reservoir of future attending physicians in the NE-RHM. Graduate medical education establishes an attractive base of hospital affiliation for those completing their training and helps to ensure the future quality of care by developing a cadre of well-qualified practicing physicians affiliated with the institution.

- The NE-RHM maintains independent, hospital-based fellowships and residency programs and also participates in the University of Connecticut School of Medicine Integrated Residency Training Programs. The NE-RHM's residency programs and all of the University of Connecticut's Integrated Residency Training Programs have been approved by the Accreditation Council on Graduate Medical Education.

- Accreditation Council on Dental Education. The NE-RHM is also a member of the Council on Teaching Hospitals and the Association of American Medical Colleges. A list of residencies offered at the NE-RHM through the University of Connecticut School of Medicine is included in **Exhibit 16.**

- The NE-RHM offers programs for various allied health professions and disciplines to rotate through various departments of the NE-RHM. These allied health professionals include medical technologists, radiological technologists, physical therapists, respiratory therapists and technicians, physician assistants, pharmacists and nurse practitioners.

In addition, the NE-RHM has successfully deployed many quality tools and best practices to help achieve an optimal patient and family experience through a patient-centered continuum of comprehensive quality services.

The NE-RHM believes that what can be measured can be improved. Accordingly, The NE-RHM*'s* service lines integrate a variety of clinical data bases as registries for standardized bench marking and quality performance assessment. The NE-RHM has received a wide range of quality accolades as a result of these efforts. (Refer to **Exhibit 9**). SMHS also has received a wide range of quality accolades. Please refer to **Exhibit 1**.

By joining the NE-RHM, SMHS can participate more directly in this effort. The chances of success of this value-based payment initiative are also reinforced by the track record Dr. Gilfillan has earned through his leadership of the Federal Center for Medicare and Medicaid Innovation, which oversaw the creation of accountable care organizations and bundled payments for Medicare.

SMHS sees its decision to join the NE-RHM as the best plan to address the continued reduction in federal and state funding while preserving its 108+ year legacy of providing health care services to all residents in its service area regardless of their ability to pay.

Trinity Health is intently focused on the delivery of high-value Triple Aim outcomes that improve the health of those it serves, reduce the per capita cost of delivering care, and that improve the quality of care and satisfaction of our patients. The infographic to the right highlights Trinity Health's view of what the organization needs to become to thrive in the future environment. The Trinity Health strategic plan focuses on building a people-centered health system to achieve the vision of becoming a mission-driven, innovative health organization that will become a national leader in improving the health of our communities and each person we serve as a trusted health partner for life.

Trinity Health's PEOPLE-Centered 2020 strategy is focused on its population health journey to improve the health of its communities and the experience of care for patients. Trinity Health's strategy is to build a people-centered health system in which the people it serves are placed at the center of every behavior, action and decision in the Trinity Health system. For Trinity Health, success will be measured against the Triple Aim objectives –its ability to actually deliver on all three dimensions of better health, better care and reduced costs.

Trinity Health has established a Unified Clinical Organization ("UCO") that provides a data and evidence-based infrastructure for clinicians across the Trinity Health system to

advance a culture of safety and high reliability. The UCO's goal is to consistently deliver the highest quality, safest and most efficient care for every patient, every time, in every Trinity Health location. Led by clinicians, the UCO offers a new way of working together to advance a culture of safety, quality, patient satisfaction and high reliability at each of our healthcare organizations.

Through the UCO, Trinity Health is:

- Advancing a culture of safety, with the goal of achieving zero clinical defects;
- Leveraging intellectual capital and best practices across Trinity Health;
- Becoming a world-class provider of care able to attract and retain the best talent, including physicians and other caregivers; and
- Delivering seamless care across the continuum of integrated health resources.

The UCO provides the infrastructure to make it easier for Trinity Health's affiliated clinicians and associates to deliver the finest care to each patient. Trinity Health-New England, Inc. will have access to this infrastructure and will participate in UCO initiatives. Examples of recently completed initiatives include cardiac surgery, interventional cardiology, palliative care, ambulatory heart failure and ambulatory diabetes. Additional collaboratives currently in the implementation, improvement and control phases are: sepsis, diabetes, perinatal safety, joint and spine surgery, peri-operative, falls, medication reconciliation and emergency medicine.

To date, the results of these initiatives have been impressive. Recent system-wide safety accomplishments across Trinity Health include:

- Sepsis mortality rate decreased from 15.8% to 11.2% between FY 2010 and December 2014. Total lives saved from FY 2010 to December 2014 = 2328.
- Vaginal Birth After Cesarean Section (VBAC) serious reportable events remain at zero, following a new policy implemented in April 2009.
- Elective deliveries before 39 weeks decreased from 4.7% in April 2010 to 0.5% in January 2015 for Trinity Health.
- Medication Reconciliation composite score (both admission and discharge data) has stayed consistent at 88% in FY2015 year to date.
- The Pressure Ulcer rates have declined from 3.8% in FY 2008 to 0.01% in January 2015 for all of Trinity Health.
- Severity Adjusted Mortality rate is at 83% of the expected rate in FY2015 for all of Trinity Health.
- Sponge accounting - zero retained sponges in FY 2014 for sites post-sponge accounting implementation.

- Safety Checklist Perfect Patient Score improved from 48% January 2013 to 81% July 2014.

Additionally, Trinity Health sponsors the annual Trinity Health Clinical Conference. The conference features leading industry professionals and nationally recognized leaders and showcases best practices. The conference includes numerous concurrent workshops presented by Trinity Health's RHMs describing proven methods to reduce costs, improve safety, quality, and service and increase employee and patient satisfaction with "take-home" implementation strategies.

Further, Trinity Health has adopted the Magnet Recognition Program® as the framework upon which its nursing program is being built. The Magnet Recognition Program® recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Consumers rely on Magnet designation as the ultimate credential for high quality nursing. Developed by the American Nurses Credentialing Center, Magnet is the leading source of successful nursing practices and strategies worldwide. A number of Trinity Health's nursing leaders are Magnet appraisers, and the directors across Trinity Health share their expertise, programs, and best practices through a monthly support network meeting. Trinity Health actively promotes academic progression and advanced education for nurses.

Last, Trinity Health sponsors a number of education and training programs focused on increasing clinical quality and patient safety. Currently, sharing of best practices occurs through the Trinity Health Clinical Leadership Council ("CLC"), a nationwide organization comprised of Trinity Health Chief Medical Officers, Vice Presidents of Medical Affairs and Chief Nursing Officers. The CLC sponsors system-wide clinical improvement teams and facilitates the exchange of comparative data regarding clinical and operational performance. The CLC meets two to three times per year in person and has monthly teleconferences focused on quality care and patient safety.

SMHS will participate in all these programs, taking away best practices and additional learnings to supplement its favorable quality and patient satisfaction scores. In short, Trinity Health's approach to clinical quality will complement and build upon SMHS strong clinical quality. This combined approach to clinical quality will significantly benefit SMHS patients.

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

This proposal will preserve local access to healthcare for the patients in the SMHS service area, including the indigent and Medicaid recipients by providing a greater

level of long term financial stability for SMHS. The integration of SMHS into the NE-RHM is anticipated to enhance access and quality of health care.

The proposed transaction will facilitate the continuation of SMHS's 108+ year commitment to providing health care services to patients in the communities it serves in the dynamic and changing environment of health care delivery. SMHS will build on this foundation and its own long-standing commitment to quality and clinical excellence. As previously noted, the NE-RHM is well recognized for its commitment to quality care as evidenced by the extensive list of awards and recognitions (See **Exhibit 9)**, and will be an excellent partner for SMHS.

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

As outlined in the answer to Section 1 of this application, the integration of SMHS into the NE-RHM is the best and most viable option available to assure the long term access to health care services for SMHS's target population.

As part of the integration of SMHS into the NE-RHM, the service line and support platform approach described previously will be used to enhance the quality of the services provided by SMHS, ensure the continuity of the service delivery system, close gaps in services where possible and reduce the costs of some services based on group purchasing contracts or specific service contract replacements.

While an overall decrease in inpatient volume is anticipated across healthcare due to a shift towards population health management, it is projected that the Hospital's average daily census will continue to be strong through coordinated care delivery and the availability of the NE-RHM infrastructure and service line support. Overall, it is anticipated that outpatient volume will increase over 6% by FY 2019.

The financial documents contained in **Exhibit 17** indicate the financial impact of the proposal and include the following:

- $100 million in capital investments within the first five years with a focus on strategic growth and infrastructure development and expansion and upgrades of facilities, services and equipment.
- Annual cost savings of approximately 1% of SMHS current operating expense in the areas of purchased services, supply chain, insurance and risk management, treasury, tax and compliance.

The NE-RHM and SMHS are committed to preserving a viable health care organization dedicated to providing health care services that meet the needs of the Saint Mary's community for the foreseeable future. Together the new health care organization formed as a result of this merger will be more than the sum of its parts; the new organization will improve the community's health by delivering high quality, cost effective, coordinated care across a broad continuum.

10. How will this proposal help improve the coordination of patient care (explain in

detail regardless of whether your answer is in the negative or affirmative)?

SMHS joining the NE-RHM delivers many benefits which will improve the coordination of patient care including:

- Investments in a shared information services infrastructure for the health ministry, it will allow for ease of sharing data and collaborating on population health management initiatives;
- Increased access to options to care offered by the NE-RHM and its partners;
- A strong commitment to people centered care and population health; and
- Providing better use of limited health manpower resources through combination of the treatment of specific patient populations e.g. cancer cardiovascular services and joint replacement services between the two organizations.

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

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

Medicaid and indigent persons will have the same access to the high quality services that they currently have. There will be no change in access to services for Medicaid recipients and indigent person as a result of this proposal. Please see response to Question 4j, Supplemental CON Application Form for Transfer of Ownership of Hospital for information on charity care and financial assistance for indigent person.

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

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

This question is not applicable because Medicaid recipients and indigent persons will continue to be served by SMHS irrespective of this proposal. Please see response to Question 11 above.

13. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from

this proposal, including, but not limited to, the addition of any imposed facility fees.

SMHS has been a vital part of the healthcare infrastructure of the Greater Waterbury region for over 108 years. Preservation of this healthcare resource ensures access to primary care providers as well as a wide range of outpatient, emergency and inpatient services. SMHS delivered over $290 million dollars to individuals in 2015 alone. (See **Exhibit 17**).

Neither the NE-RHM nor SMHS has charged facility fees for most of the organizations' services. In letters provided to the Attorney General in December 2013 (See **Exhibit 18**), NE-RHM identified three locations where facility fees are charged and SMHS identified five. Patients are informed of these facility fee charges in writing before services are delivered.

No new facility fees will occur as a result of SMHS joining the NE-RHM.

Financial Information

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

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

In an era of healthcare reform and diminishing resources, the transfer of SMHS's membership to the NE-RHM is consistent with the goals of the Department of Health's Statewide Health Care Facilities and Services Plan ("the Plan"). One of the guiding principles of the Plan is to "provide financial stability and cost containment of health care services".

The NE-RHM has long been focused on lowering the cost of delivering care by providing the right care at the right time in the right location. The NE-RHM also emphasizes meeting or exceeding quality standards in the delivery of care. Recognition of the high quality of all three Applicants is included elsewhere in this application in the listing of awards received from various health care quality ranking organizations such as the Leapfrog organization, The Joint Commission, US News and World Report to name a few. The NE-RHM also believes in healthcare innovation as a way to promote both quality and cost containment. The NE-RHM was also an early adopter of partnership arrangements with its physicians designed to ensure high improvements in quality, enhanced patient outcomes and efficient management of health care resources both financial and clinical occurred within its system as well as the use of Value Analysis in its Materials Management Department to generate

group purchasing savings.

The history of Saint Francis Hospital and Medical Center and Mount Sinai hospitals is relevant to this application because it demonstrates the value and cost savings that result from consolidation. As SMHS becomes part of the NE-RHM, it will also have the advantage of working within a system with a strong record of providing cost containment measures as it improves the quality of care.

Saint Francis Health*Care* Partners:

Saint Francis/Mount Sinai Physician Hospital Organization (PHO) was incorporated on June 17, 1993 as a not-for-profit, 501c3 taxable organization as Saint Francis Hospital and Medical Center and Mount Sinai Hospital were in the midst of merging and uniting the two medical staffs. The name was legally changed to Saint Francis Health*Care* Partners (SFHCP) on January 27, 2009.

Today, Saint Francis Health*Care* Partners ("SFHCP") is a clinically integrated network of physicians comprised of independent healthcare practitioners, hospital based or affiliated groups and other facilities that serve as a vehicle through which the clinical and related economic interests of patients, providers and payers become aligned. As the oldest functioning PHO in Connecticut, SFHCP is recognized both locally and nationally. The vision created by the initial thought leaders and advanced through a physician led Board of Directors and by the strong alliance between Chris Dadlez, CEO of Saint Francis Hospital and Medical Center, and Jess Kupec, CEO of Saint Francis Health*Care* Partners. The strength of sharing a common vision has propelled the organization into a nationally recognized ACO. Throughout SFHCP's twenty-one year history, SFHCP has been recognized by the healthcare industry for our physician leadership in driving a contemporary approach to improving quality and reducing unnecessary costs. SFHCP was one of the first organizations nationally to develop an integrated approach to implementing an Electronic Health Record (EHR). The alignment within the NE-RHM network has been so vital to its success that it will have full EHR adoption with its entire physician membership by the end of 2015. This is a significant accomplishment as compared to local and national benchmarks.

As a result of its depth of clinical integration, SFHCP has the ability to enter into contractual arrangements with the payor community that binds the entire membership by achieving minimum criteria for participation. As a result, the single-signature model fosters greater collaboration and network continuity. As market forces initiated by Federal reform have accelerated so too has our strategy. Employers and patients alike are now engaged and are demanding change. SFHCP realizes that the status quo is no longer acceptable and that the transparency of cost and quality are becoming the benchmarks for which employers and consumers will select where they receive their healthcare.

As SMHS becomes part of NE-RHM, it will have the advantage of working within a system with a strong record of providing cost containment measures as it improves the quality of care.

Foundation of our Contracting Model:

The commitment at NE-RHM to its patients is "best *care* for a lifetime". All components to our overall mission and focus begin there. Even our contract strategy is driven by being focused on providing the best options for its patients. The foundation of the contracting model is based upon a joint contracting relationship with Saint Francis Hospital and Medical Center and approximately 1,000 provider members. Through the years, this contracting model has derived its success by developing congenial relationships with the payor community. Through the joint contracting model, which is necessary in the attainment of the network's goals of financial stability, improving quality of care, reducing costs through efficiencies, and improving access to care, these relationships continue to be enhanced by its providers' commitment to achieving the best results for all patients accessing the Saint Francis Network.

The current contractual model is based upon the ideals of accountable care and shared savings – a collaborative approach with the payors in which all participating have the incentive to drive value to patients, including better quality, care coordination and total cost efficiency.

CMS Medicare ACO:

SFHCP has been developing its Accountable Care Strategy, with the intent of being prepared for the transition from a Fee for Service reimbursement model to an Accountable Care Organization (ACO) model which focuses on population management and the delivery of cost-effective, high quality care. SFHCP was recognized as an ACO by CMS and began participating in the CMS Medicare Shared Savings Program on January 1, 2013. Although the first year results were good, SFHCP did not achieve a level of savings allowing CMS to share these savings with the ACO. Although the organization did not meet the required minimum levels of savings, SFHCP did reduce costs by $1.1 million and achieved 5 out of 7 quality metrics. This is evidence that SFHCP is heading in the right direction and is a strong indication of our potential future success if we continue investing in our mission and vision.

Current Contracts:

SFHCP is currently contracted with the following major payors inclusive of these value-based components as noted below:

Value-Based Commercial Agreements:

Anthem, Inc.
Aetna, Inc.
CIGNA
ConnectiCare
UnitedHealthCare/Oxford- in progress

Covered Lives: 82,000

Value-based Medicare Advantage Agreements:

Anthem BlueCross BlueShield- in progress
Aetna, Inc.
ConnectiCare
UnitedHealthcare/Oxford
WellCare Health Plans

Covered lives: 31,000
Total covered lives: 113,000

Focus on the Future for SMHS:

As SMHS faces the challenges and opportunities presented by healthcare reform, the organization realizes the importance of executing a new business model that allows the entire SMHS enterprise to move in a strategic direction to meet the objectives of the Triple Aim[2]. SMHS's goal over the next couple of years is to build its infrastructure to such a degree that it is capable of accepting full risk opportunities. SMHS engagement with Trinity Health presents all organizations involved with a real opportunity to drive value to the market by improving cost to the individuals and employers while improving their healthcare outcomes.

With specific reference to the proposed affiliation with SMHS, the capabilities of SFHCP and potential for strategic alignment offer significant opportunities for both organizations and the patients they serve. SFHCP's demonstrated ability to collaborate effectively with payers and develop mutually beneficial business relationships will clearly assist SMHS, particularly as they transition away from a fee-for-service payment environment to a "population health management model". It is rather difficult for a hospital the size and scale of SMHS to build an infrastructure capable of succeeding under a risk-based population health model. Experience and trends at the national level clearly demonstrate this. Our integrated approach between our physicians and the acute care hospital setting can also serve as a model in our affiliation with SMHS.

Cost Containment Protocols

1. **Post-Acute Care Partnerships**: One of the substantial costs to the healthcare system is readmissions to the hospital. Readmissions occur for many reasons, one of which is poor coordination of care. Consequently, Trinity Health – New England, Inc. embarked upon the development of a post-acute care affiliated network that closely links the hospital to the continuum of post- acute providers including

2 The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim". (a)Improving the patient experience of care (including quality and satisfaction); (b) Improving the health of populations; and (c) Reducing the per capita cost of health care.

nursing homes and home health agencies. These tighter linkages provide for more accurate and seamless transitions of patients from the hospital to the next level of care and reduce the costly re-hospitalization of patients. The NE-RHM's commitment to continuing care for its patients is shown in the January 8, 2015 announcement of the formal Post-Acute Care Network through Saint Francis Health*Care* Partners, a NE-RHM affiliate, with the following long term care, rehabilitation and home care entities:

- Hospital For Special Care, in New Britain, CT
- Mount Sinai Rehabilitation Hospital in Hartford, CT
- Avon Health Center in Avon, CT
- Touchpoints at Bloomfield in Bloomfield, CT
- Touchpoints at Manchester in Manchester, CT
- Riverside Health and Rehabilitation Center in East Hartford, CT
- Glastonbury Health Care Center in Glastonbury, CT
    - McLean Home in Simsbury, CT
    - Evergreen Health Care Center in Stafford Springs, CT
    - Hughes Health and Rehabilitation in West Hartford, CT
    - The Reservoir in West Hartford, CT
    - Saint Mary Home in West Hartford, CT
    - West Hartford Health and Rehabilitation Center in West Hartford, CT
    - Kimberly Hall South in Windsor, CT
    - Masonicare Partners and Masonicare Home Health and Hospice

The post- acute affiliated providers will have access to the NE-RHM's Electronic Medical Record which will allow them real time access to patient discharge information. In addition, these providers have committed to implementing the INTERACT tool kit which focuses on readmission avoidance and will be participating in real time readmission reviews for any patient that has been readmitted to the NE-RHM.

Once SMHS joins the NE-RHM the system will create a similar agreement with a group of post - acute affiliated providers located in the Waterbury market place. This group of affiliated post – acute providers will use the comparable transfer agreements, have access to NE- RHM's electronic medical record and use the INTERACT tool kit to manage patient flow between the post – acute providers and SMHS.

2. Materials Management

The NE-RHM uses an internal Value Analysis Committee and its group purchasing agreements with Premier, Ascend and Yankee Alliance to drive costs down within its various clinical and non-clinical areas. Over the last three years this rigorous focus on value and price has generated over $11 million in savings for goods and services purchased by the NE-RHM. In addition, both NE-RHM and SMHS have participated in many state and federal surveys and discussions to improve healthcare delivery,

financing and provider supply.

3. Charity Care

Nothing in the proposed transfer of assets will reduce SMHS's or the NE-RHM's commitment to the provision of health care services to the poor, including the indigent and Medicaid patients. Saint Francis Hospital and Medical Center's inpatient and outpatient patient population is comprised of 23.8% Medicaid recipients in FY 2014 and SMHS's Medicaid population also represented 44% of its inpatient and outpatients in FY 2014. It is expected that this will remain level or increase in the coming years. Also, both organizations have and will continue to have self-pay and financial assistance policies if this proposed CON is approved. These policies are contained in **Exhibit 20**. For a more detailed explanation of the community benefit of both organizations, please refer to **Exhibit 21** which contains the 2014 Community Benefit Reports for Saint Francis *Care* (now known as NE-RHM) and SMHS. Both organizations are committed to charity care, which has a direct impact on the financial strength of the health care system in Connecticut.

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

Please refer to table 3 below**.**

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

This question is not applicable.

17. Include as an attachment:

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

Please refer to **Exhibit 22.**

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

Please refer to **Exhibit 17**.

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

Please refer to Table 4 below.

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

Please refer to **Exhibit 17**

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

There are no projected incremental losses from operations resulting from implementation of this CON proposal.

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

This question is not applicable.

Utilization

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

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

Please refer to **Table 5 and Table 6, *infra*.**

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

Patient volume is expected to remain constant for the next 4 years except for an expected decrease of 0.5% for Adult Medical and Surgical patients. This decrease is attributed to the continued shift from treating patients in the inpatient setting to the outpatient setting. As medical advances continue to decrease the need for

inpatient hospitalization, patients will increasingly be seen in as same day patients for surgeries or treated in ambulatory settings.

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

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

Please refer to **Table 7, *infra*.**

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

Please refer to response to question 8a in the Main CON application.

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

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

Please refer to **Table 8, *infra.* .**

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

Table 9 is not applicable since this proposal is an organizational change rather than a change in clinical services.

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

The NE-RHM does not believe this Certificate of Need proposal will have any effect on existing providers as there will be no expected change in any services at SMHS.

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

SMHS's affiliated providers currently have the option to refer to SMHS or elsewhere as they deem appropriate.

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

The existing referral patterns will remain unchanged.

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

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

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

This question is not applicable as this proposal will not result in an unnecessary duplication of services. All of SMHS's health services will remain as is if this proposal is approved.

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

The NE-RHM believes that SMHS is a unique part of the healthcare infrastructure of the State of Connecticut and a critical component of the health system in their primary service area. By SMHS joining the NE-RHM, the residents in the SMHS geographic service area can continue to receive services from the healthcare providers they currently have established relationships with in their communities. In this fashion this proposal preserves access to a diverse group of health care providers and ensures continued competition with the other healthcare organizations that serve patients in the region.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

This table is not applicable.

TABLE 2
SERVICE AREA TOWNS

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

Town*	Reason for Inclusion

*** Village or place names are not acceptable.**

Please refer to **Exhibit 11.** The 16 towns and 2 boroughs in the SMHS's Total Service Area have historically been the towns included in the Hospital's service area. These towns accounted for 93.5% of the Hospital's volume in FY2015.

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

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

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

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

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

This table is not applicable.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	TABLE 4 PROJECTED INCREMENTAL REVENUES AND EXPENSES FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	-	-	-	-
Total Operating Expenses	-	(1,585)	(3,133)	(3,241)
Gain/Loss from Operations	-	1,585	3,133	(3,241)

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

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs) FY 2012	FY 2013	FY 2014	FY 2015
DISCHARGES:				
Adult Med. & Surg.	23,879	24,318	23,264	23,951
Maternity	3,212	3,035	3,075	2,910
Psychiatric	2,010	2,064	1,961	1,961
Rehabilitation	650	685	660	705
Pediatric	-	-	-	-
Neonatal ICU	278	268	294	275
Newborn	2,732	2,681	2,640	2,535
TOTAL	32,761	33,051	31,894	32,337

1. Fiscal Year is October - September.

2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital.

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.**
**** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.**
***** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.**

TABLE 6
PROJECTED UTILIZATION BY SERVICE

SMHS

Service*	Projected Volume FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

Trinity Health – New England

SERVICE*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
DISCHARGES:				
Adult Med. & Surg.	26,699	32,486	32,560	32,383
Maternity	3,222	4,341	4,325	4,309
Psychiatric	2,130	2,508	2,498	2,489
Rehabilitation	883	759	759	759
Pediatric	-	-	-	-
Neonatal ICU	312	412	411	410
Newborn	2,750	3,626	3,612	3,598
TOTAL	35,996	44,132	44,165	43,948

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX
SMHS

Payer	TABLE 7 APPLICANT'S CURRENT & PROJECTED PAYER MIX									
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare	5,289	45%	5,313	45%	5,276	45%	5,240	45%	5,214	45%
Medicaid	3,703	31%	3,696	31%	3,683	31%	3,671	31%	3,653	31%
CHAMPUS & Tricare	22	0%	22	0%	22	0%	22	0%	22	0%
Total Government	9,014	76%	9,031	76%	8,981	76%	8,933	76%	8,888	76%
Commercial Insurers	2,601	22%	2,613	22%	2,604	22%	2,594	22%	2,581	22%
Uninsured	103	1%	102	1%	102	1%	101	1%	100	1%
Workers Compensation	129	1%	129	1%	129	1%	129	1%	128	1%
Total Non-Government	2,833	24%	2,844	24%	2,835	24%	2,824	24%	2,810	24%
Total Payer Mix	11,847	100%	11,875	100%	11,816	100%	11,757	100%	11,698	100%

Trinity Health-New England

Payer	CURRENT		PROJECTED							
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare *	14,821	45.8%	16,467	45.7%	19,643	44.5%	19,774	44.8%	19,678	44.8%
Medicaid*	7,962	24.6%	8,906	24.7%	11,864	26.9%	11,814	26.7%	11,756	26.7%
Champus & TriCare	77	0.2%	87	0.2%	112	0.3%	113	0.3%	112	0.3%
Total Government	22,860	70.7%	25,460	70.7%	31,619	71.6%	31,701	71.8%	31,546	71.8%
Commercial Insurers*	9,071	28.1%	10,046	27.9%	11,837	26.8%	11,783	26.7%	11,725	26.7%
Uninsured	268	0.8%	307	0.9%	401	0.9%	399	0.9%	397	0.9%
Workers Compensation	138	0.4%	183	0.5%	275	0.6%	282	0.6%	280	0.6%
Total Non-Government	9,477	29.3%	10,536	29.3%	12,513	28.4%	12,464	28.2%	12,402	28.2%
Total Payer Mix	32,337	100.0%	35,996	100.0%	44,132	100.0%	44,165	100.0%	43,948	100.0%

Assumptions:

1. FY 2015 (actual) includes only Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - FY 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's.

*** Includes managed care activity.**

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

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 15**
WATERBURY	59.3%
NAUGATUCK	9.4%
WOLCOTT	5.8%
WATERTOWN	5.3%
PROSPECT	3.2%
SOUTHBURY	1.9%
CHESHIRE	1.6%
THOMASTON	1.5%
MIDDLEBURY	1.4%
WOODBURY	1.2%
SOUTHINGTON	0.7%
OXFORD	0.6%
BETHLEHEM	0.6%
BEACON FALLS	0.5%
PLYMOUTH	0.3%
MORRIS	0.1%
Subtotal Total Service Area	**93.5%**
Other Towns	6.5%
Total	**100.0%**

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

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

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
N/A	N/A				

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

Supplemental CON Application Form
Transfer of Ownership/Sale of Hospital
Conn. Gen. Stat. § 19a-638(a)(2) & § 19a-486

Applicants: Trinity Health, Trinity Health-New England, Inc. and Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

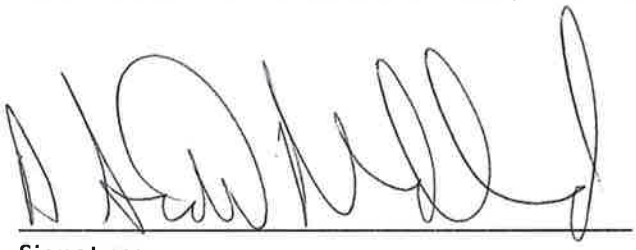
Project Name: Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.

AFFIDAVIT

Applicant: **Trinity Health**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **D. Scott Nordlund, Executive Vice President** of **Trinity Health** being duly sworn, depose and state that **Trinity Health's** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature

11·25·2015

Date

Subscribed and sworn to before me on 11-25-2015

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

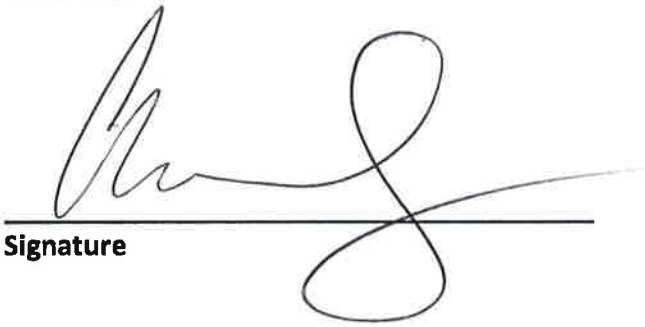
Claudia A. Crane, Notary Public
State of Michigan, County of Oakland,
My Commission Expires 11/17/2019
Acting in the County of _____

AFFIDAVIT

Applicant: **Trinity Health-New England, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, Christopher Dadlez, President and Chief Executive Officer of Trinity Health-New England, Inc., being duly sworn, depose and state that **Trinity Health-New England, Inc.'s** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Signature 11-20-15 **Date**

Subscribed and sworn to before me on 11-20-15

Jaxeanne Christina Lubin-Scafuredi, Esq.

Notary Public/Commissioner of Superior Court

~~**My commission expires:**~~ _____

AFFIDAVIT

Applicant: **Saint Mary' Health System, Inc. and Saint Mary's Hospital, Inc.**

Project Title: **Trinity Health-New England, Inc. to become the sole member of Saint Mary's Hospital, Inc.**

I, **Chad Wable, President and Chief Executive Officer** of **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** being duly sworn, depose and state that **Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.** information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 11/23/15 Date

Subscribed and sworn to before me on 11/23/15

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

My commission expires: VICTORIA CIPRIANO NOTARY PUBLIC MY COMMISSION EXPIRES FEB. 28, 2017

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

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

Because clinical health services are not being directly affected by this proposal, patient care will not be affected. Therefore, the typical type of transition plan is not needed where patients have to be moved or transitioned physically to other services because of a lack of continuity. If clinical services are added or eliminated in the future, the Applicants will seek a Certificate of Need as required.

The initial transition in this proposal will be directed at steps toward operational integration that would have a positive impact on the delivery of clinical services to patients of SMHS into the NE-RHM, and for identifying opportunities to achieve efficiencies and improvements in quality and access of health care services.

The NE-RHM has taken the additional steps in its relationship with SMHS by signing the Transfer Agreement (see **Exhibit 3**).

If the Certificate of Need is granted by the Office of Health Care Access, then NE-RHM plans to complete the acquisition of SMHS by 10/1/16.

The integration of SMHS under the NE-RHM organization will benefit both organizations and the community by ensuring the ongoing operation of SMHS, thereby continuing its 108+ year legacy of providing quality healthcare services in the Waterbury, Connecticut area.

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

i. Legal chart of corporate or entity structure including all affiliates.

The corporate organization charts are attached in **Exhibit S1**. The proposed organization charts provided include the NE-RHM (which will include SFHMC) and SMHS as part of this new organization. (See **Exhibit 4**)

ii. Governance or controlling body.

SMHS currently has a self-perpetuating community-based board of 21 members.

Reserve powers are held by the Archbishop of the Archdiocese of Hartford. Under the proposed new governance structure, NE-RHM (whose sole member is Trinity Health) will be the sole member of SMHS. Two members of the NE-RHM Board of Directors will be appointed by Trinity Health for a period of three years, with eligibility for re-appointment. These members will be from the SMHS community. The SMHS Board will remain unchanged other than the addition of the CEO of Trinity Health – New England, who will be an ex-officio member.

iii. **List of owners and the % ownership and shares of each**.
The applicants are non-stock, non-profit corporations and have no equity owners. **Exhibit S1** illustrates the percentage ownership of each of the SMHS affiliates. The proposed organization charts provided include the NE-RHM and SMHS as part of this new organization (**Exhibit 4**).

2. Historical and Projected Volume

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

TABLE A
HISTORICAL AND CURRENT DISCHARGES

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs) FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	23,879	24,318	23,264	23,951
Maternity	3,212	3,035	3,075	2,910
Psychiatric	2,010	2,064	1,961	1,961
Rehabilitation	650	685	660	705
Pediatric	-	-	-	-
Neonatal ICU	278	268	294	275
Newborn	2,732	2,681	2,640	2,535
TOTAL	32,761	33,051	31,894	32,337

1. Fiscal Year is October - September.
2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital

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

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

F/N The Applicants' Fiscal Year is from October 1 – September 30.

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

SMHS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	41,395	41,900	40,663	40,360
Maternity	2,775	2,609	2,855	2,775
Psychiatric	3,994	4,099	3,993	4,139
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,390	1,303	1,240	1,227
Newborn	2,022	1,922	2,173	2055
Total	**51,576**	**51,833**	**50,924**	**50,556**

Trinity Health - New England

SERVICE**	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Adult Med. & Surg.	119,951	122,793	116,294	117,978
Maternity	10,105	9,478	9,630	8,732
Psychiatric	14,856	14,999	14,627	14,738
Rehabilitation	9,274	9,378	8,542	8,839
Pediatric	-	-	-	-
Neonatal ICU	6,018	5,626	5,010	5,068
Newborn	6,604	6,479	6,307	5,974
TOTAL	166,808	168,753	160,410	161,329

1. Fiscal Year is October - September.

2. Includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital

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

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.)

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

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

TABLE C

PROJECTED DISCHARGES BY SERVICE

SMHS

Service*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

TRINITY HEALTH - NEW ENGLAND, INC.

SERVICE*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	26,699	32,486	32,560	32,383
Maternity	3,222	4,341	4,325	4,309
Psychiatric	2,130	2,508	2,498	2,489
Rehabilitation	883	759	759	759
Pediatric	-	-	-	-
Neonatal ICU	312	412	411	410
Newborn	2,750	3,626	3,612	3,598
TOTAL	35,996	44,132	44,165	43,948

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

SMHS

Service*	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Adult Med. & Surg.	40,900	40,645	40,392	40,140
Maternity	2,914	2,914	2,914	2,914
Psychiatric	3,769	3,769	3,769	3,769
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,220	1,220	1,220	1,220
Newborn	2,228	2,228	2,228	2,228
Total	**51,031**	**50,776**	**50,523**	**50,271**

Trinity Health – New England Inc.

SERVICE*	FY 2016	FY 2017	FY 2018
Adult Med. & Surg.	128,755	158,339	158,729
Maternity	9,402	13,005	12,954
Psychiatric	15,863	18,001	17,926
Rehabilitation	10,950	9,791	9,791
Pediatric	-	-	-
Neonatal ICU	5,402	6,330	6,311
Newborn	6,519	8,674	8,641
TOTAL	176,891	214,140	214,352

1. Fiscal Year is October - September.
2. FY 2016 (budget) includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital for the full fiscal year. And Saint Mary's Hospital for July through September.
3. FY 2017 - 2019 (projected) includes Saint Francis Hospital and Medical Center; Mount Sinai Rehabilitation Hospital and Saint Mary's Hospital.

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

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

F/N The Applicants' Fiscal Year is from October 1 – September 30.

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

Overall, volume has remained relatively constant for the time periods reflected in the table above. The largest decrease was in overall days as the average length of stay continues to improve as a direct result of continuous improvements made in the efficiency of delivering care.

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

Inpatient volume is projected to decrease 0.5% each year, respectively, from FY 2017 through FY 2019 as utilization of inpatient services shifts to outpatient services as a result of increasing population health management.

3. Clear Public Need

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

No. The proposal is being submitted in accordance with OHCA requirements; however, the parties also intend to comply with all applicable federal and state antitrust laws and regulations.

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

While SMHS had planned to partner with another health care provider even before the PPACA was passed in order to have a system in the future that could support the kind of quality health care SMHS is accustomed to providing, there is no question that the PPACA only added further reasons to make this move now. With a shift from a fee for service structure to a population health focus, the PPACA requires an investment of time in new programming and information technology. This, in turn, requires a substantial commitment of capital, and is better made with a partner who has already had experience in this area.

4. Supplemental Questions

a. Were alternative proposals or offers considered and, if so, how did they compare to this proposal with respect to provider diversity, consumer choice and access to affordable quality health care?

Alternative proposals were considered. Trinity Health and NE-RHM have an outstanding model for diversity of services as well as a strong program to serve diverse populations. Consumers will select the best quality health care that is affordable. Trinity Health and NE-RHM have made their services affordable in the past and plan to continue to do so in the future.

b. For the first three years following the hospital's transfer of ownership, provide a detailed list and explanation for any consolidation, reduction, elimination or expansion of existing services, or any new services planned to be introduced.

As of the filing of this application, there are no planned changes to services offered by SMHS within its service area. As part of the NE-RHM, SMHS will continually monitor demand for services and adapt to them either through its existing offerings or collaboratively through the regional health ministry.

c. Please provide a detailed explanation of any planned staffing changes following the hospital's transfer of ownership and discuss how these changes will impact the accessibility, quality and affordability of care.

As of the filing of this application, there are no planned staffing changes that will occur in the near term as a result of this proposal.

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

The Greater Waterbury Health Improvement Partnership ("GWHIP"), which includes Saint Mary's Hospital, Waterbury Hospital, the City of Waterbury Department of Health, the Connecticut Community Foundation, StayWell Health Center, the United Way of Greater Waterbury and other community partners conducted a comprehensive Community Health Needs Assessment ("CHNA") in 2013. The community health issues identified in the CHNA as priorities and areas of focus were: (1) Access to Care; (2) Mental Health and Substance Abuse; (3) Obesity and Chronic Disease; and (4) Tobacco Use. A copy of the CNHA is attached as **Exhibit 5**.

Saint Mary's Hospital ("SMH") developed an Implementation Strategy that addresses the four community health priorities. SMH's Board of Directors met on September 12, 2013, to review the findings of the CHNA and the Implementation Strategy. The Implementation Strategy is attached as **Exhibit S2** and is being rolled out over three years. On September 12, 2013, the Boards of Directors of SMHS and SMH voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives (see **Exhibit 10** for Board minutes). To date, the following has occurred.

Access to Care Initiatives

- Collaborating with Access Health CT to help residents gain access to health insurance. SMH hosted several enrollment fairs during the 2013 – 2014 enrollment period.
- SMH transitioned ownership of the Children's Health Center ("CHC") to StayWell Health Center. This allowed the CHC patients to access StayWell's extensive offerings of health and social services.
- SMH developed and implemented a nurse navigator program in the Emergency Department ("ED") to improve access to primary care and behavioral health. The nurse navigator reviews between 60 and 200 patient records per week. The navigator contacts many of these patients to coordinate follow-up care and connect patients with other resources.
- Educating health care providers on resources for uninsured/underinsured and low income patients.
- Providing free screenings for uninsured and underinsured patients. For example, SMH provides free breast and cervical cancer screenings, diagnostic and treatment referral services through a Connecticut Department of Health grant.

Mental Health and Substance Abuse Initiatives

- A "Super Track" initiative has been implemented in the ED. This initiative has led to improved patient flow, reduced length of stay, and increased patient satisfaction.
- SMH is a participant in the Connecticut Behavioral Health Partnership, which is organized through Value Options.
- Evaluating ways to implement the Community Care Team program based at Middlesex Hospital.

Obesity and Chronic Diseases Initiatives

- Collaborating with Brass City Harvest to offer a farmer's market every Friday during the summer months for local residents.
- Participating in the American Heart Association Mission Lifeline Program.
- Developing improved meal choices at SMH. SMH began offering the Mindful Meal program, which includes healthy low-fat and low calorie options, to patients, staff and the community.
- Providing a nurse educator to patients to coordinate post-acute services and provide patient and family education. SMH is one of eleven hospitals in the country to participate in the American College of Cardiology Patient Navigator Program.

Tobacco Use Initiatives

- Working with the Harold Leever Regional Cancer Center to enhance smoking cessation programs.
- Evaluating opportunities to pilot an incentive program to increase smoking cessation rates.

The implementation of these initiatives will be greatly enhanced as SMHS becomes a member of the NE-RHM.

Following the initial CHNA, the work of the Greater Waterbury Health Improvement Partnership has continued. This year we completed a new survey, the Behavioral Risk Factor Surveillance System (BRFSS). This is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. In Waterbury, more than 400 members of the community were surveyed. Results from the survey will be integrated with the original CHNA to develop a more comprehensive view of the health of our community, and to further focus and refine our efforts. Workgroups focused on the four priority health areas continue to meet on a monthly basis, and a steering committee provides oversight of the entire process.

Most recently, the Greater Waterbury Health Improvement Partnership (GWHIP) has been accepted to participate in the Centers for Disease Control and Prevention (CDC) pilot Learning Collaborative for Community Health Improvement (CHI).

As part of the Learning Collaborative, SMHS and our community partners will be joining nine other CHI partnerships from around the country to learn about the CHI process and its underlying principles in greater depth, and to use the CHI Navigator to strengthen our ability to conduct an effective and collaborative CHI process. This program is designed to provide training and group technical assistance through a series of webinars and phone calls from national community health improvement experts as well as facilitated peer-to-peer sharing and learning with other CHI partnerships.

The NE-RHM Community Need Assessment, (**Exhibit 21**) as filed with the Office of Health Care Access, identifies similar priorities and areas of focus. Implementation strategies employed by the NE-RHM will buttress the strategies currently in place in Waterbury. In this document there are listed problem areas including obesity, diabetes, behavioral health, and alcoholism and substance abuse. These disease categories are also discussed as prevalent chronic diseases in Connecticut that need to be improved upon in The Department Of Health Publications called “Healthy CT 2020” published in March 2014 and “Live Healthy CT” published in April 2014. The Applicants also reviewed the “Statewide Health Care Facilities and Services Plan 2014 Supplement” which identifies at risk and vulnerable populations in Connecticut in chapters 3 – 5.

As shown in the NE-RHM implementation plan, the organization is addressing these diseases by offering related classes to improve the population health in its community. The NE-RHM also currently services many patients with chronic diseases in its various service lines including Primary Care, and Behavioral Health. The NE-RHM has an outpatient Diabetes Care Center that serves many people with Diabetes and offers many outreach and educational activities within the community that address these chronic diseases. The NE-RHM and SMHS understand the importance of treating and improving the overall health of its populations. SMHS will benefit from the NE-RHM's knowledge and experience with improving chronic diseases.

The NE-RHM has also made it a priority to address health equity as evidenced by the establishment of the Curtis D. Robinson Center for Health Equity (CDRCHE) in 2011. Curtis D. Robinson is a NE-RHM board member, African American business leader and cancer survivor. The CDRCHE grew out of a community engaged program focused on the disparity in health outcomes of African American men impacted by prostate cancer. Over the years, the CDRCHE team has addressed health disparities by community engagement; providing health education and outreach to underserved communities; offering tailored navigation for patients; and participating in research and data analysis about health disparities for the community served by the NE-RHM. The CDRCHE serves as a platform throughout the NE-RHM to address health equity issues by bridging the divide between the community and the healthcare system and focusing on a long term commitment to change. This organization and its approach will be available for SMHS as well.

The NE-RHM Strategic Implementation Plan (developed by the CDRCHE and approved by leadership) outlines four priorities that highlight a "systems change" approach to resolving the issues identified in the Community Health Needs Assessment. The four strategic priorities are: Improving Communication; Addressing Barriers to Healthcare Services; Providing Coordinated Care and Targeting Social Determinants of Health. Within each of these priority areas specific activities have been developed, with input from those affected, to address the identified need. The community outreach approach integrates input from healthcare providers, community agencies and those in need of services.

Some of the activities that have been developed to address the four priority areas within the NE-RHM include: the development of a language services program; increased commitment to cultural competency training; focus on appropriate use of Emergency Room resources; engagement with community groups to navigate patients to needed resources; partnering with state agencies to provide critical training to communities with limited resources for mental health support; and collaborating with faith communities to address chronic health conditions of concern within their institutions. Each of these activities will be replicated and tailored to address the needs identified within the communities reached by the NE-RHM.

The priorities of the Connecticut Department of Public Health are outlined in the Health Promotion Plan published in 2014 entitled "Live Healthy Connecticut". In this document, Dr. Jewell Mullen, the state Commissioner of Public Health, identifies three strategies as necessary for success of the plan (which are parallel to those identified in our strategic implementation plan), they include: an environmental approach which acknowledges the need for change outside of the healthcare system to achieve sustainable outcomes (addressing social determinants of health); improving the system for delivery of care which ensures access to healthcare services (decreasing barriers to care) and improving linkages between the community and clinical settings (communication and coordination of care).

In addition, the Statewide Health Care Facilities and Services Plan, the 2014 Supplement and the Healthy CT 2020 consider multiple determinants of health and provide an overview of initiatives focused on reducing health inequities, improving health outcomes and enhancing care coordination all of which are priorities for the NE-RHM going forward. In fact, Dr. Marcus McKinney, D.Min., Vice President of Health Equity and Health Policy at the NE-RHM, was the co-chairperson of the work group on Mental Health, Alcohol and Substance Abuse which set the priorities for this area of work. Dr. Marcus McKinney's work on this work group shows the NE-RHM's commitment to addressing health inequities.

In addition to the above activities, Dr. McKinney is also engaged in national activities surrounding health disparities. For instance, as part of the NE-RHM's effort to encourage other institutions to develop programs that encourage health care organizations to reach out to populations that often have difficulty accessing the traditional health care system, Dr. Marcus McKinney presented "Simple Solutions in Health Equity; Bridging communities to Health Systems" at the 2015 National Catholic Health Association General Assembly on June 7, 2015 in Washington D.C.

The Curtis D. Robinson Center for Health Equity exists to engage and empower community members to collaborate with healthcare providers and create innovative programs that address identified health disparities. The Curtis D. Robinson Center encourages communities who have not been heard to reach out to health providers and help shape the trajectory of change in healthcare. Relationships with the community, Catholic Charities and other human service organizations are discussed and successful approaches to a collaborative dialogue will be identified in the presentation.

The NE-RHM is also beginning its efforts related to its 2015 Community Benefits report. For the 2015 Community Health Needs Assessment, the NE-RHM has partnered with Data Haven, a non-profit organization with a 25-year history of public service to Greater New Haven and Connecticut whose mission is to improve quality of life by compiling, sharing, and interpreting public data for effective decision making. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, DC.

Clearly, given the above, the NE-RHM and SMHS are currently addressing the community needs within the SMHS community and the state of CT and will continue to do so if this CON is approved. Also, SMHS's efforts will be significantly enhanced and expanded with the expertise, experience and support of the NE-RHM if this CON application is approved.

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

If the proposal is approved, a review of the NE-RHM, Trinity Health and SMHS's current charity care, uncompensated care, financial assistance policies and procedures and bed funds will be reviewed to ensure compliance with new requirements effective January 1, 2016.

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

SMHS currently collaborates with both FQHC's located in Waterbury (StayWell, Community Health Centers, Inc.). These relationships will continue as SMHS provides acute care and behavioral health services for these patients whose medical home is either one of these FQHCs.

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

As noted earlier in the application, the NE-RHM has committed to ensure capital investment at SMHS of $100 million over the first five years after closing for routine capital, information technology and other capital needs. Historically, SMHS's has been investing on average $12 million per year in routine capital. This proposal will allow SMHS to accelerate these investments to maximize the efficiency and effectiveness of the delivery of care.

SMHS's current routine capital needs over the next five years include the following:

- Hospital facility upgrades $22 million
- Replacement of clinical equipment $18 million

In addition, based on preliminary SMHS strategic planning efforts, additional capital is needed for strategic investments and would likely include:

- Information technology upgrades and electronic health record $12 million
- Urgent care / ambulatory care $10 million
- Ambulatory pavilion on campus $25 million

- Convert to private patient rooms $8 million
- Clinically integrated network development $5 million

As healthcare continues to evolve, the allocation of capital to SMH's and the NE-RHM strategic initiatives will be integrated with the Trinity Health strategic and financial planning process.

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

- Cancer care is a key priority. Due to the aging of the population, cancer care is an important service to the community. Through the recently announced clinical affiliation with Smilow Cancer Hospital and Yale New Haven Hospital, the NE-RHM cancer program will utilize the same clinical guidelines as Smilow. Furthermore, as the only NCI designated cancer program in the state, patients of SMHS following the transaction, will have access to state of the art clinical trials and treatments.
- Movement towards ambulatory surgery is a national and local trend. This enables care to be delivered in the lowest cost setting with the best outcomes for the patient.
- Population Management is essential to develop. The NE-RHM has already developed a robust heart failure program that will be a priority to extend to SMHS not only for inpatients but across the continuum including the skilled nursing facility and in the ambulatory setting. The NE-RHM has realized improvements in readmission rates and will readily extend this expertise to SMHS.

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

It is anticipated that SMHS will maintain their current Medicare and Medicaid provider numbers and there will be no changes to those contracts as a result of this proposal. After the implementation of this proposal, SMHS will continue will continue to operate under its own license and its current commercial contracts are expected to remain in effect. Upon expiration of current commercial contracts, SMHS contract negotiations will be part of the broader the NE-RHM payor contracting process.

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

As noted previously, the applicants will develop a plan to adequately fund Saint Mary's pension obligations.

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

The existing high quality of care of both the NE-RHM and SMHS will be maintained if this Certificate of Need is approved. Also, please refer to response to 9a in the Main CON.

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

See **Exhibit S3**

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

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

See **Exhibit S4**

ii. annual or periodic review and/or revision to the hospital's pricing structure (chargemaster or pricemaster); and

SMHS performs annual and periodic CPT/HCPC/revenue coding updates and revisions per applicable changes from AMA and Medicare. SMH pricemaster is adjusted throughout the year as costs for supplies change. Our contracts have pricemaster increase thresholds. There are no plans to change this process as a result of this proposal.

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

SMHS performs periodic market assessments and pricing sensitivity analyses on an as needed basis. There are no plans to market assess as a result of this proposal.

n. Provide <u>monthly</u> financial reports that include statistics for the current month, year-to-date and comparable month from the previous year for the following:

Monthly Financial Measurement/Indicators

Refer to **Exhibit 17**

o. For the most recent tax year, provide a copy of the Hospital's IRS Form 990 (you may reference the filing if previously submitted to OHCA). With respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H (Financial Assistance and Certain Other Community Benefits at Cost) and Part II of Schedule H (Community

Building Activities), provide a projected amount for each line item for the first three years following the change in ownership and describe the hospital's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H.

The most recent IRS Form 990 is attached in **Exhibit S5** along with the projected amount in **Exhibit S6**. SMHS is committed to supporting its community and is projecting a 3% increase per year. As part of the NE-RHM, SMHS will be able to collaborate on planning activities on a regional level leveraging the expertise and resources of the regional health ministry.

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

The NE-RHM currently participates in a national group purchasing program that provides advantageous pricing for many products and supplies. The proposal will allow SMHS to further benefit from this program as well as provide other opportunities with vendors such as information technology where SMHS will be able to leverage the buying power of NE-RHM.

The NE-RHM's continued focus on population health and the development of an infrastructure to support risk-based contracts with payers will also be available and a benefit to SMHS after the proposal is approved. This will allow SMHS to transition to risk-based contracting and position SMHS favorably with payers.

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

As the NE-RHM and SMHS continue to reduce costs through standardization of clinical protocols and clinical integration, the ultimate impact will be a decrease of costs to the consumer as these efforts will likely result in the elimination of duplicate services and removal of waste within the system and across the continuum of care. These savings have not been quantified at this time.

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

SMHS has several programs in place to adhere to the National Standards on Culturally and Linguistically Appropriate Services. SMHS has contracted with FSW (formerly Family Services Woodfield) to provide face to face sign language interpreters for the hearing impaired. Video conferencing is also available for sign language interpretation.

SMHS also contracts with Language Line Services, which provides translation for non-English speaking patients. Two handset phones are strategically placed within SMHS. The patient has one handset while the provider has the other handset. The Language Line Services' interpreter participates in the patient visit by providing translation over the telephone.

SMHS also participates in the Connecticut Hospital Association Diversity Collaborative (the "Collaborative"). As part of the Collaborative, SMHS hosts an educational fair during Cultural Diversity Week. At this fair, brochures on CLAS standards are distributed.

In addition, SMHS Hospital's Education Department has incorporated Cultural Diversity Training in the annual e-learning program, which is mandatory for all employees. Cultural Diversity Training is also part of new employee orientation.

Finally, SMHS Hospital's Education Department and Nursing Administration Department are evaluating other training programs to increase adherence to CLAS. SMHS will support these existing programs that increase adherence to CLAS standards.

The following is a description of the NE-RHM's efforts in establishing National CLAS Standards.

To address health disparities and prioritize health equity the NE-RHM led by its CEO, Christopher Dadlez, created the Curtis D. Robinson Center for Health Equity, a platform that supports and leads health equity initiatives – whose home is the first floor of the Urban League of Greater Hartford. In 2009 the Saint Francis Board of Directors passed a resolution that embraced the National Call to Action goals of increased use of Real Data, improved Cultural Competency Training, and more Diversity in Leadership. In 2011 the Curtis D. Robinson Center for Health Equity was founded and in 2012 it moved to a dedicated space designed to provide easy access to those who live in the surrounding community. The position of Vice President of Community Health Equity was established, and a dedicated, multicultural staff charged with transformation of our healthcare system based on AHA goals and the NE-RHM's unyielding commitment to community engagement which results in decreased health disparities in a meaningful and measurable way.

Activities at NE-RHM that fulfill the CLAS Standards include:

<u>*Governance, Leadership, and Workforce:</u>

- Updated training for intake staff on the collection of race and ethnicity implemented 3/2014.
- Updated policy for the use of language services implemented 9/2014

- Edits to the policies to explicitly include gay and lesbian populations for visitation completed 9/2014.
- 99% of staff trained for cultural competency in 2014

*Communication and Language Assistance:

- Language Program Developed: Increase in resources across the organization for addressing language services to include our 3 + 1 options (Dual Handset Phones; Video
- Remote Interpreting; In-person interpreting + Document Translation)
- Full Time Language Services Coordinator Hired 11/2014
- Signage regarding language services availability updated and replaced 12/2014
- Training for all staff on new language services resources completed 3/2015
- Pilot training for bilingual staff to become qualified medical interpreters completed in 9/2014
- System for translation of documents into needed languages on demand implemented 2/2015

*Engagement, Continuous Improvement, and Accountability:

- Leadership of the State Diversity Collaborative by the CEO of Saint Francis Hospital and Medical Center
- Collection and reporting of data for the CT Diversity Collaborative (Diversity in Leadership and Governance; Cultural Competency Training; Use of Diverse Suppliers)
- Quarterly reporting to the Board of Directors on Center for Health Equity activities
- Partnership with community organizations to respond to needs identified through assessment activities.
- Support of Diversity Intern through the Institute for Diversity in Healthcare Management
- Creation of an Accelerated Development Program for diversity staff
- Saint Francis Diversity Collaborative Team – regular meetings since 2011
- Development of a Health Equity Scorecard
- Regular Community Leader Roundtable Discussions
- Completion and Distribution of the Community Benefit Report
- Update of Saint Francis Hospital and Medical Center's website outlining activities and providing copies of relevant publications.

To address health disparities in a comprehensive and effective manner it is necessary not only to provide appropriate services but to change and improve those services so that they are accessible to all populations regardless of degree of English language proficiency; cultural beliefs; racial, ethnic and gender identities. Hence, the NE-RHM has updated three of its current policies addressing communication and language services,

patients' rights and equal employment and Affirmative Action. Please refer to **Exhibit S7** to see these policies. By making changes at the policy level, NE-RHM is able to hold all staff accountable for providing care which embraces inclusive strategies that have proven to impact health outcomes. For example, research has shown that providing information to patients with limited English proficiency in their native language can result in better health outcomes and patient satisfaction. See **Exhibit S8** for citation - "Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters." Research from NIH has concluded that implementation of cultural competency needs to take place at the systems level - as a "framework which enables systems, agencies and group of professionals to function effectively to understand the needs of groups accessing care." The NE-RHM is embracing this approach by making changes at all levels of the organization to address health equity disparities.

NE–RHM will support these initiatives with SMHS and is confident that they will continue and deepen if this proposal is approved.

Saint Mary's HOSPITAL

Certificate of Need

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EXHIBIT 1

Saint Mary's Hospital Awards and Accomplishments

2013

- ✓ Named a Top Performer on Key Quality Measures® by The Joint Commission for heart attack, heart failure, pneumonia and surgical care (2012 data)
- ✓ American Heart Association Get With The Guidelines®–Heart Failure Gold Quality Achievement Award
- ✓ American Heart Association/American Stroke Association Get With The Guidelines®–Stroke Gold Quality Achievement Award
- ✓ Named an American College of Cardiology Patient Navigator Hospital (among first 11 in nation)
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR®) ACTION Registry–GWTG Gold Performance Achievement Award for 2013
- ✓ American Heart Association's Mission: Lifeline® Bronze Receiving Quality Achievement Award for heart attack care; named a STEMI Receiving Hospital
- ✓ Recognized by BlueCross BlueShield Association as a Blue Distinction Center+ for Cardiac Care
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ Rated among the five highest scoring teaching hospitals in the country for safety by Consumer Reports (not an endorsement ; recognition cannot be published)
- ✓ Cancer Program awarded a three-year accreditation with commendation from the American College of Surgeons' Commission on Cancer (CoC)
- ✓ Nuclear Medicine Department awarded a three-year accreditation from the American College of Radiology for all nuclear cameras

2014

- ✓ Named a Top Performer on Key Quality Measures® by The Joint Commission for heart attack, heart failure, pneumonia and surgical care (2013 data)
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR®) ACTION Registry—Get With The Guidelines (GWTG) Gold Performance Achievement Award for 2014
- ✓ American Heart Association's Mission: Lifeline® Silver Plus Receiving Quality Achievement Award for heart attack/STEMI care
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ One of the top two hospitals for safety in Connecticut based on safety ratings from Consumer Reports (not an endorsement; recognition cannot be published)
- ✓ Awarded a $32,750 grant from Susan G. Komen Connecticut to provide screening mammograms, diagnostic mammograms and ultrasounds for women through the Navigating Breast Health Program, which is dedicated to reducing high rates of breast cancer mortality and late-stage diagnoses
- ✓ Received a $1.7 million reimbursement from the Centers for Medicare and Medicaid (CMS) for achieving the Stage 1 Year 2 objectives required to demonstrate meaningful use of our Electronic Health Record

- ✓ #1 in Connecticut for the CMS Value Based Purchasing program; performance based on quality and service metrics including CMS core measures, the Hospitals Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and mortality

2015

- ✓ Rated high performing in Heart Failure in the U.S. News & World Report Best Hospitals for Common Care ratings
- ✓ American College of Cardiology's National Cardiovascular Data Registry (NCDR) ACTION Registry–Get With The Guidelines (GWTG) Gold Performance Achievement Award for 2015
- ✓ Comprehensive Center accreditation from the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and the American Society for Metabolic and Bariatric Surgery (ASMBS)
- ✓ Recognized by Anthem Blue Cross Blue Shield with a Blue Distinction® Center designation in the area of bariatric surgery as part of the Blue Distinction® Centers for Specialty Care program
- ✓ Designated as an Aetna Institutes of Quality® (IOQ) facility for Bariatric Surgery
- ✓ Saint Mary's Urgent Care Centers in Naugatuck and Wolcott received the Certified Urgent Care designation from the Urgent Care Association of America
- ✓ Re-verified as a Level II Trauma Center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS)
- ✓ Cleverley + Associates Community Value Five Star® Award
- ✓ Cleverley + Associates Community Value 100® Award
- ✓ Recognized as a Breastfeeding Friendly Worksite by the Connecticut Department of Public Health and the Connecticut Breastfeeding Coalition
- ✓ Named one of the 2015 America's Best Hospitals for Heart Care by the Women's Choice Award, a leading consumer advocacy group

cleverley+associates

2015 Community Value Leadership Award Winner

Community Value Five-Star®

Saint Marys Hospital

EXHIBIT 2

Healthcare Transformation Task Force Members

March 19, 2015

Providers Members

Advocate Health Care

Aledade

Ascension

Atrius Health

Dartmouth-Hitchcock Health

Dignity Health

Evolent Health

Heritage Provider Network

Optium

OSF Healthcare

Partners Healthcare

Premier

Providence Health & Services

SLL Health

SSM Health

Trinity Health

Tuscan Medical Center

Payers Members

Aetna

Blue of California

HCSC Health Care Service Corporation

Blue Cross Blue Shield Massachusetts

Purchasers Members

Caesars Entertainment

PBGH Pacific Business Group in Health

Patients and Families Members

National Partnership for Women and Families

Partners Members

The Dartmouth Institute

Mark McClellan, Brookings Institute

Patientping

remedy partners

Source: Healthcare Transformation Task Force website 3/19/15 www.hcttf.org

EXHIBIT 3

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01**.

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01**.

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06**.

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06**.

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02**.

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"**Certification of AFTAP**" has the meaning set forth in **Section 6.22(c)**.

"**Church Plan**" has the meaning set forth in **Section 6.22(e)**.

"**Closing**" has the meaning set forth in **Section 5.01**.

"**Closing Date**" has the meaning set forth in **Section 5.01**.

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01**.

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a)**.

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04**.

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth in **Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**NE-RHM**" has the meaning set forth in the preamble.

"**NE-RHM Controlled Subsidiary**" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"**NE-RHM Providers**" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"**Trinity Health Controlled Subsidiary**" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"Withdrawal Liability" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

cont do: a, b, c, o, q
consent for: d, e h, i, k, m, n, p
notify: f, g, j, l

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c),** and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a **"Covered Entity"** (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary (**"Interested Person"**) directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12**.

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06.** The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

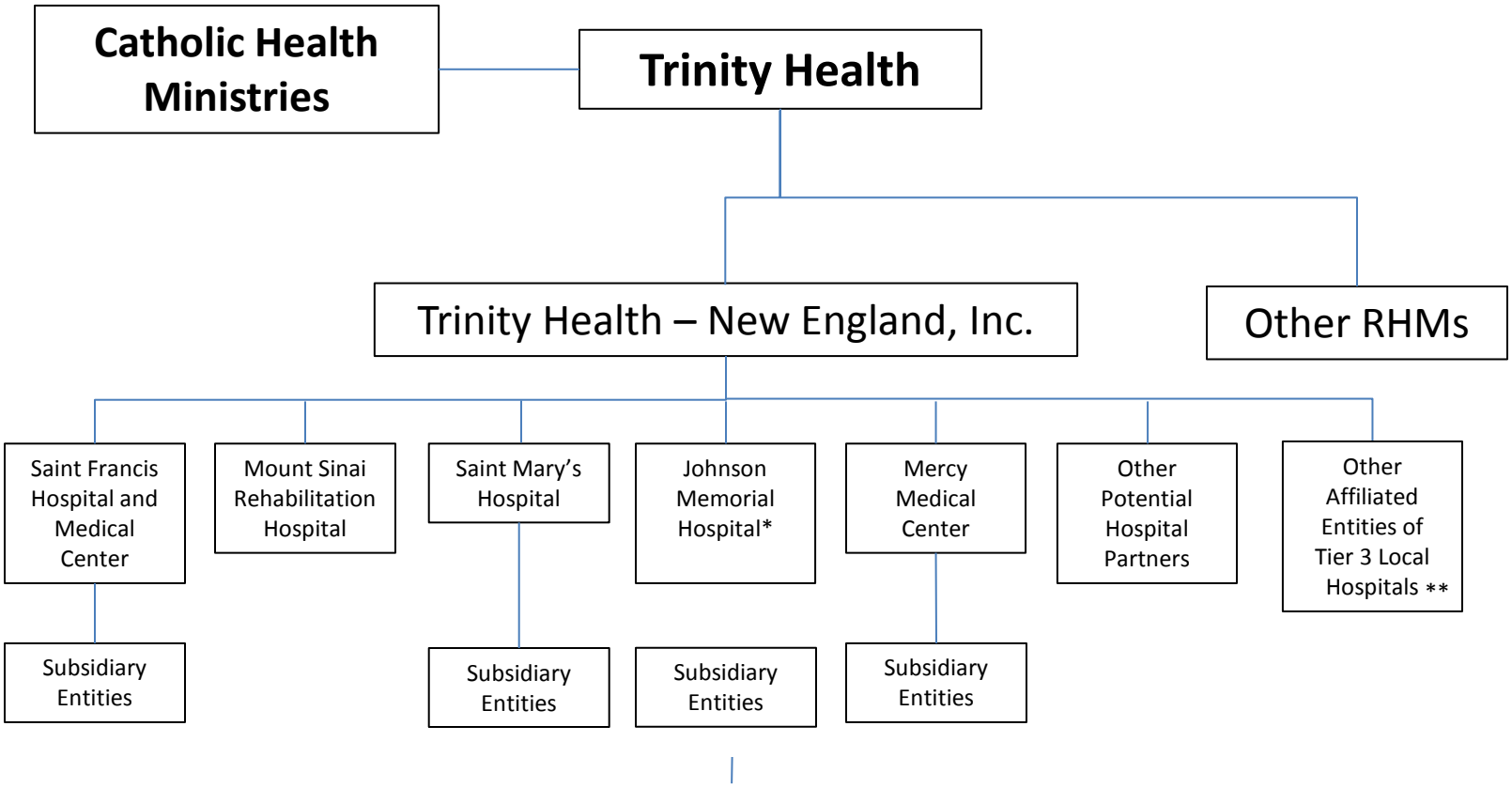
SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBIT 4



*(1/1/2016 anticipated closing date)

** This refers to non-hospital entities that are on the same level as the hospital entities noted, such as Saint Francis Medical Group, Inc., Saint Francis Hospital Foundation, etc.

EXHIBIT *5*

Saint Mary's Strategic Plan 2016-2020

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Introduction and overview

Introduction and Overview

The materials included in this document represent an update to the existing plan that was created last year. The strategies are rooted in our mission (which remains unchanged) and our vision, but have been fine tuned to reflect what we have learned and how the environment has evolved.

In 2014, our physicians, staff and community helped to craft a plan for 2015-2019 which contemplated advancing population health, establishing a Clinically Integrated Network and Accountable Care Organization and investing in Ambulatory care.

After living with it for nearly a year, we wanted to fine tune and continue to focus on the core elements of the plan. We have taken the time to incorporate suggestions from our physicians, staff and community on how to ensure that we are focused on the appropriate initiatives given the evolving healthcare climate both at Saint Mary's and regionally. Substantive change was made in the service line initiatives so that we are more focused and appropriating resources to successfully execute these initiatives.

We have also spent the year contemplating joining a system of regional/national health systems with the belief that joining the Regional Health Ministry will accelerate successful achievement of the plan. Saint Mary's is also focusing on Trinity's Healthy 2020 health wellness vision.

Strategic Plan Process

2016 Drivers of Strategic Plan

Payer Activity

1. Payer consolidation
2. Accountable care reimbursement changes like bundled payment plans and value based purchasing
3. Increasing demand for transparency
4. Payment models changing to reflect cost and/or quality

Provider Activity

1. Non traditional competition
2. Physician alignment and integration
3. Ongoing consolidation and partnerships of CT healthcare providers (hospitals, physician groups)

Consumer Activity

1. Growth in high deductible plans
2. Consumer directed choices (with assistance from upstarts/payers)
3. Increasingly interested in ratings adding to confusion of what they mean
4. Growing demand for convenient outpatient services as inpatient activity decreases

Mission and Values

Saint Mary's Health System provides excellent healthcare in a spiritually enriched environment to improve the health of our community.

"I Care" Values

- Integrity
- Caring
- Accountability
- Respect
- Excellence

Our vision (updated for 2016-2020)

Saint Mary's will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives.

Overall strategy & initiatives

Overall strategy

"Build the wall" – Provide care to our community within our network of trusted providers.

Strategic Initiatives

Strengthen the Core

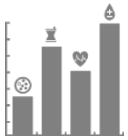
Drive continued, sustainable improvement in operations focusing on Quality & Safety, Service, Healthy People, and Financial Discipline

Cultivate a Clinically Integrated Network

Establish a team of care coordinators, strategic partnerships, structure, and support mechanisms to achieve a clinically integrated network, with coordinated care across our ecosystem

Service Line Strategy

Create comprehensive Cardiac and Primary Care service line strategy that encompasses the complete continuum of a patient's care allowing for leading levels of quality, service and efficiency



Signature Services Strategy Development

New!

Develop a laser focus on patient outcomes and experience, viewing the patient experience in a contemporary, collaborative manner with all care provided regardless of the patient's point-of-entry

Ambulatory Care Network

Create a network where every patient has access to primary care, urgent care, basic imaging and blood draw within 10 minutes of anywhere in our market

Strengthen the Core

- The core focuses on transforming our culture around the following:
  - Quality & Safety (Preventable harm & Core Quality Indicators)
  - Patient & Family Centered Service (Wait times & Satisfaction Scores)
  - Healthy & Engaged People (Health & Wellness)
  - Financial Discipline (Efficiency, Productivity, Revenue)

Strengthen the Core

SHORT TERM (1-2 YEAR) INITIATIVES

Healthy & Engaged People

- Design and implement a comprehensive wellness plan
- Design and implement a comprehensive workforce development plan

Quality & Safety

- Reduce Preventable Harm
- Improve Core Quality

Patient & Family Centered Service

- Improve the ED front end intake process
- Eliminate waiting throughout the system
- Transform services towards a Retail Orientation
- Fully optimize the patient feedback system

Financial Discipline

- Continue to improve productivity management
- Enhance cost management across the system
- Reduce overall fixed costs
- Revenue optimization

LONG TERM (3-5 YEAR) INITIATIVES

- Leverage the regional health ministry to enhance and improve all core initiatives.

Develop a Clinically Integrated Network

SHORT TERM (1-2 YEAR) INITIATIVES

- Creating the CIN structure
- Growing the attributed lives through physician alignment
- Develop and finalize payer contracting initiatives
  - MSSP
  - Anthem
  - Cigna
- Using data to improve care management
- Decrease clinical variation amongst CIN providers
- Prepare for regional system integration

LONG-TERM (3-5 YEAR) INITIATIVES

- Evolve payer contracts to risk based models
- Developing the care management models

Service Lines

Focus on Cardiac and Primary Care service lines because:

- Leverage existing service lines that have an organizational structure in place, will drive system revenue and increase market share
- Grow the number of attributed lives while preparing for the shift to population health management
- Support the Ambulatory Care Network Strategy through having primary care be one of the anchors for the access centers

Why these Two Service Lines?

Primary Care

- Foundation of referrals into the system
- Primary Care equals market share and controlling your market share
- Panel size vs. IP admissions
- Hub of the care team

Cardiac

- Strong foundation currently in place
- Currently provide a full range of services
- Market share is strong in a competitive market
- Relatively high margin for surgical procedures

Primary Care Service Lines

Goal is by 2020 to have a well managed population with 65,000 attributed lives

Short Term (1-2 Year) Initiatives

- Achieve a PCMH Level 1 designation for FMG
- Create a unifying branding approach
- Continue to recruit primary care providers to either FMG or VHA
- Open 2 Centers collocating with urgent care, x-ray, lab and specialists
- Created a referral management improvement process

Long Term (3-5 Year) Initiatives

- Create a consistent patient experience regardless of location
- Open 3 more Outpatient Centers
- EHR upgrade to allow for expedited data sharing, scheduling and integration
- Achieve a Patient Centered Medical Neighborhood designation

Focus Areas

- Retail strategy
- Smart growth
- Access

Cardiac Service Line

Goal is to increase market share to equal overall Saint Mary's market share

Short Term (1-2 Year) Initiatives

- Organic Growth across all services
- Continued development of the Electrophysiology ("EP") Program
- Expand access to services
- Provider recruitment and retention

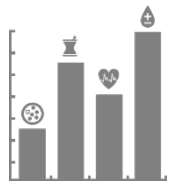
Long Term (3-5 Year) Initiatives

- Maintain a competitive edge through ensuring contemporary technology
- New service growth
- Improve quality and efficiency

Focus areas

- Outpatient growth
- Reduce outmigration
- Enhancing programs for patient convenience

Signature Services



Services that are strategic in nature and play a supporting role in the overall strategy. Work continues on them as planned.

Surgical Services

- Bariatric
  - Leverage the Centers of Excellence designation
  - Grow volume through additional provider capacity and capabilities
  - Evolve to a weight management program
- Robotic & Minimally invasive surgery
- Ambulatory surgery
  - Co-Management with NVSC

Neuro Spine

- Spine Surgery
- Head and Neck
- Co-management

Women's Services

- Focus on the Spirt of Women program
- Grow the Women's and Infants service

Emergency Department

- Reduce the front end wait
- Continue to implement the redesign of patient flow

Key Strategic Clinical Services in Development

Following services are in a planning and development stage and will be further refined within the year.

Oncology

- Need to leverage Smillow and Leever market awareness
- Comprehensive Breast Strategy
- Cancer patients require a holistic approach to care along the whole continuum
- Diagnosis, treatment and survivorship can last up to 7 years with higher utilization of health services

Orthopedics

- High margin, in demand
- Current pieces are fragmented both in care delivery and patient experience
- Comprehensive Care for Joint Replacement (“CCJR”) CMS bundled payment here
- Comprehensive rotator cuff bundled program and total joint center are potential opportunities
- Explore demand for sports medicine and concussion clinics

Develop an Ambulatory Care Network (2016)

Create a network where every patient has access to primary care, urgent care, imaging, blood draw and specialists within 10 minutes of anywhere in our market

DEFINING PRINCIPLES

- Network of ambulatory services with access points throughout our service area
- Positioned to be consumer driven for “vertical” patients
- Primary Care, Urgent Care, Imaging, Lab and Specialist’s offices are the core
- Develop strong brand identity and customer experience
- Located in retail corridors

Develop an Ambulatory Care Network

SHORT TERM (1-2 YEAR) INITIATIVES

- Continue to open our access centers (Primary Care, Urgent Care, Imaging, Lab, Specialist Space) in key strategic areas
- Transform occupational medicine towards corporate wellness
- Complete a feasibility plan for an ambulatory pavilion connected to Saint Mary's Hospital
- Complete master partnership with NVRA with go--no go decision
- Optimize medical space throughout the health system

Develop an Ambulatory Care Network

LONG-TERM (3-5 YEAR) INNITIATIVES

- Establish 5-7 ambulatory care centers in the market including primary care, urgent care, imaging and blood draw
- If feasible, build an ambulatory care pavilion connected/adjacent to Saint Mary's Hospital
- Explore development of a Digestive Disorders Center including GI
- Explore development of a Medical Fitness and Wellness strategy in conjunction with physical and occupational therapy
- Explore development of a Women’s breast center
- Create a comprehensive Cardiac Center

EXHIBIT 6

GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP

Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

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EXECUTIVE SUMMARY

The Greater Waterbury Health Improvement Partnership led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2012. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Statistical Data Profile of Waterbury, Connecticut and surrounding cities
- Household Telephone Survey with 1,100 community residents
- Focus Group Discussions with 24 health care providers and 33 community residents
- Key Informant Interviews with 205 community leaders and partners
- Prioritization Session
- Hospital Implementation Plans
- Community Health Improvement Plan (CHIP)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Documentation

A final report of the CHNA was made public in September 2013 and can be found on the partner's websites. Hospital Implementation Plans, as well as a Community Health Improvement Plan (CHIP), were developed and adopted by each appropriate authority in September 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

The Greater Waterbury Health Improvement Partnership is made up of a group of not-for-profit organizations serving the residents of Waterbury, Connecticut and surrounding communities. The Greater Waterbury Health Improvement Partnership defined their current service area as the City of Waterbury and the surrounding communities served by Saint Mary's Hospital and Waterbury Hospital. The area encompasses southwest Connecticut and is relatively large with a population of approximately 313,000 residents. The geographic area was defined by primary service area (PSA) and secondary service area (SSA). The PSA is the area that the partnership predominantly serves and the hospitals main catchment area. It comprises all of Waterbury and has a population of approximately 110,000 residents. The SSA includes portions of the surrounding communities served by the two hospitals and has a population of approximately 203,000 residents. The conclusions drawn from the various research components focus on the primary service area, the town of Waterbury, Connecticut.

CHNA Partners

- The City of Waterbury
- Connecticut Community Foundation
- Saint Mary's Hospital
- StayWell Health Center
- Waterbury Department of Public Health
- Waterbury Hospital
- The United Way

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Waterbury, Connecticut and surrounding cities was compiled.

- A Household Telephone Survey was conducted with 1,100 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health

status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Qualitative Data:

- Six Focus Groups were held with 24 health care providers and 33 community residents in February 2013.

- Key Informant Interviews were conducted with 205 community leaders and partners between February and April 2013.

Research Partner

The Greater Waterbury Health Improvement Partnership contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from the household telephone survey
- Conducted focus groups with community members
- Conducted key informant interviews with community leaders and partners
- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The Greater Waterbury Health Improvement Partnership sought community input through focus groups with health care providers and community members, key informant interviews with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Additionally, language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Greater Waterbury Health Improvement Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, the Greater Waterbury Health Improvement Partnership prioritized community health issues and developed an implementation plan to address prioritized community needs.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in the Greater Waterbury Health Improvement Partnership service area.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Waterbury Department of Health, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

Secondary Data Profile Key Findings

This section serves as a summary of the key takeaways from the secondary data profile. A full report of the findings is available through the Greater Waterbury Health Improvement Partnership.

Demographic Statistics

According to U.S. Census Bureau estimates (2009-2011), the total population in Waterbury, Connecticut is 110,075, a decline of 2.55% since 2000. The majority of residents identify as White (58.2%), indicating a less diverse population when compared to peer cities, but a more diverse population when compared to all of Connecticut. Approximately 19% of residents identify as Black/African American and 30.1% identify as Hispanic or Latino. The primary spoken language is English, but 31.6% of residents speak a language other than English at home. The median age in Waterbury is 35.2, which denotes a younger population when compared to Connecticut, but an older population when compared to most peer cities (U.S. Census Bureau, 2012).

Table 1. Overall Population (2009-2012)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
White	78.6%	58.2%	32.2%	46.7%	48.6%	59.6%
Black/African American	9.8%	19.4%	37.2%	34.4%	34.5%	14.8%
Asian	3.8%	1.7%	2.5%	4.9%	3.6%	8.05%
Two or more races	2.3%	5.6%	4.0%	2.9%	1.9%	1.7%
Hispanic or Latino (of any race)[b]	13.0%	30.1%	42.4%	26.3%	36.7%	24.4%

Source: U.S. Census Bureau, 2012

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race, for example, White Hispanic

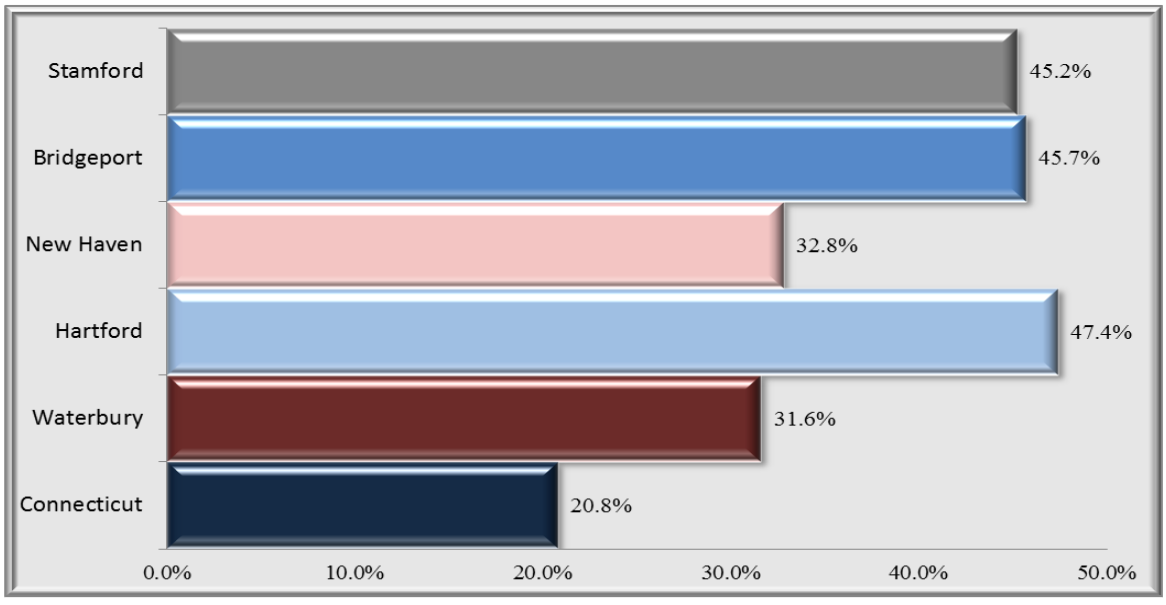


Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

Waterbury is comprised primarily of family households (63.2%), which are defined as more than one person living together, either as relations or as a married couple. These households and nonfamily households are less likely to live in owner-occupied units (49.6%) compared to Connecticut (68.9%), but more likely to live in owner-occupied units compared to most peer cities. The median value for owner-occupied units is $164,000, which is lower than the median value across the state ($293,100) and all peer cities (U.S. Census Bureau, 2012).

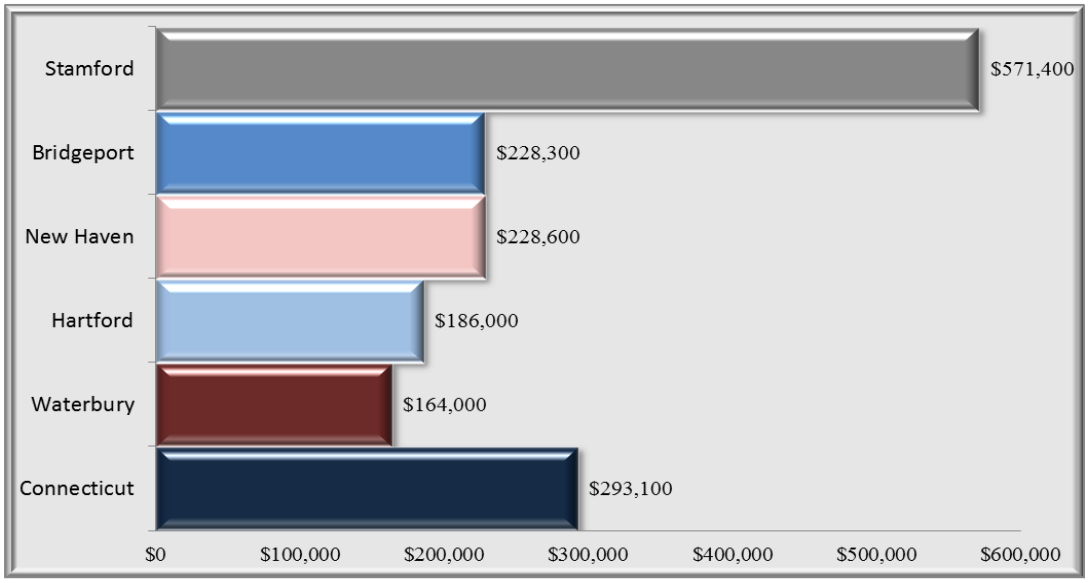


Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

Approximately 40% of Waterbury residents aged 15 years and over have never been married. This is greater than the percentage across Connecticut (31.8%), but lower than the percentage across most peer cities. Among those residents who have been married, a higher percentage are divorced (11.6%) compared to Connecticut (10.2%) and all peer cities (U.S. Census Bureau, 2012).

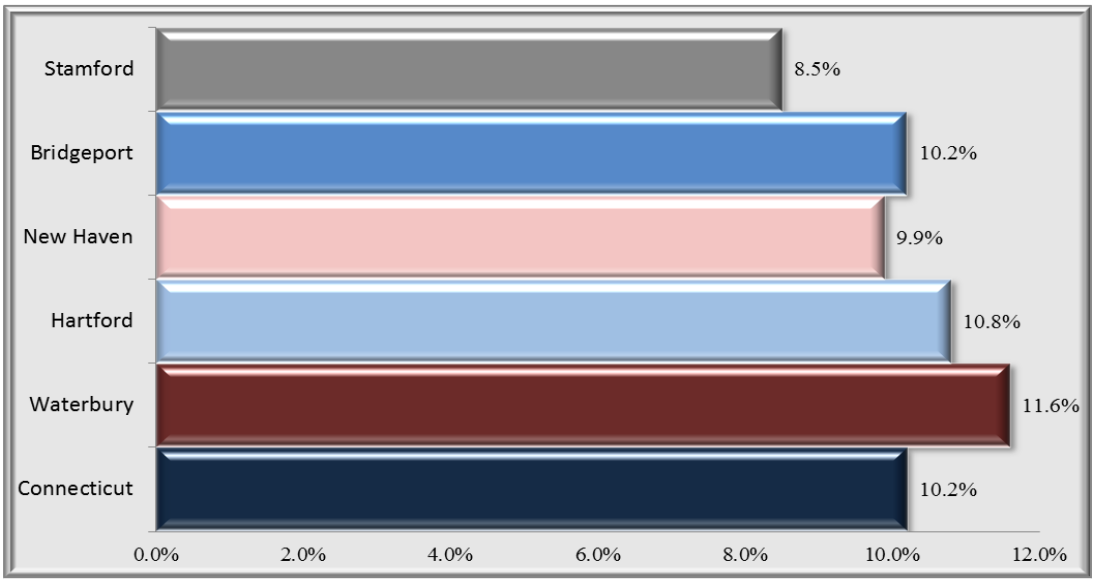


Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

The median income for households and families across Waterbury ($41,499 and $49,059 respectively) is lower than across all of Connecticut ($69,243; $86,395). However, it is higher when compared to most peer cities. The same trend is true of the median income for workers. The percentage of families and individuals living in poverty in the past 12 months is higher in Waterbury than in all of Connecticut (U.S. Census Bureau, 2012). More residents in Waterbury are also enrolled in social assistance programs like Temporary Family Assistance and Medicaid when compared to Connecticut and most peer cities. Between the years 2011 and 2012, 28.2% of residents were enrolled in Temporary Family Assistance and 38.1% were enrolled in Medicaid. Medicaid enrollment has been on the rise across all of Connecticut and its cities since 2006 (Connecticut Department of Social Services, n.d.).

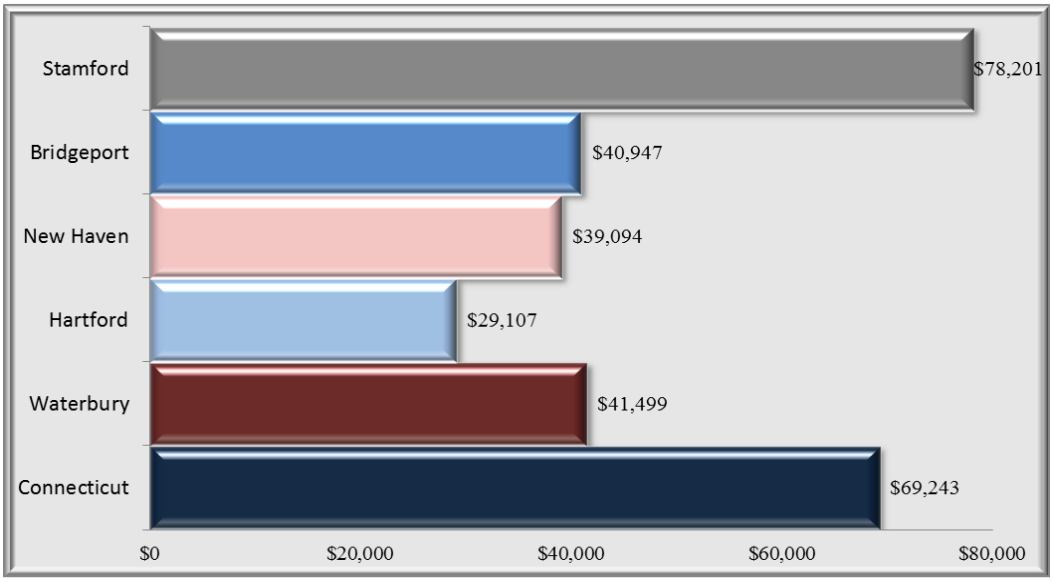


Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

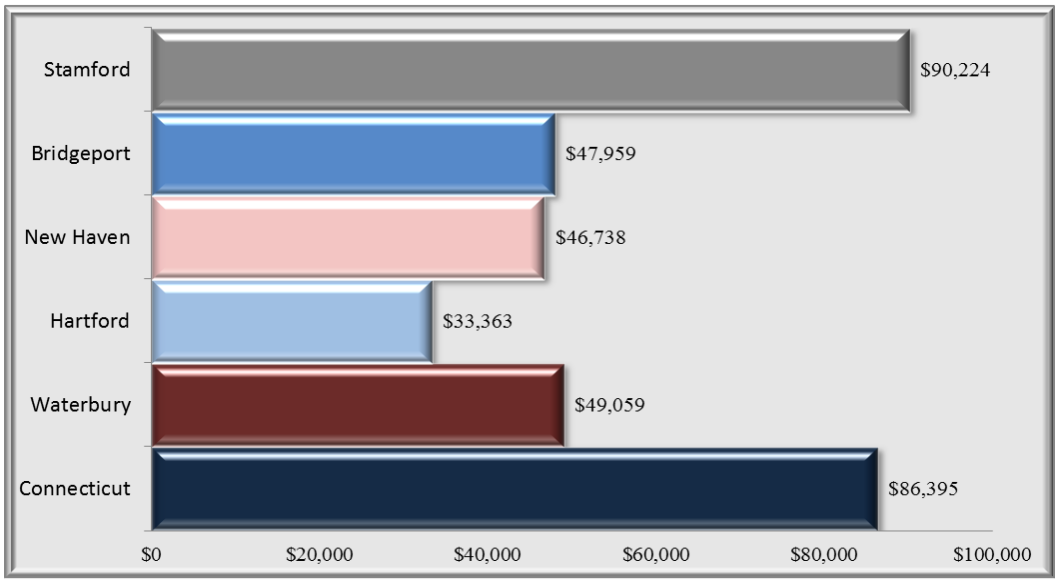


Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Families	6.7%	17.1%	29.9%	20.8%	18.0%	7.5%
With related children < 18 years	10.8%	26.3%	39.3%	30.0%	25.3%	11.6%
With related children < 5 years	12.5%	22.4%	46.1%	21.3%	20.6%	12.7%
Married couple families	2.3%	5.6%	9.3%	7.4%	7.3%	3.4%
With related children < 18 years	3.1%	7.7%	12.1%	11.2%	10.7%	4.5%
With related children < 5 years	3.4%	7.5%	11.3%	9.2%	6.0%	3.8%
Families with female householder, no husband present	22.9%	35.5%	44.5%	36.9%	34.1%	22.1%
With related children < 18 years	30.8%	44.3%	51.6%	44.9%	40.8%	30.4%
With related children < 18 years	40.1%	47.7%	60.8%	42.7%	41.1%	35.8%
All people	9.5%	20.6%	32.9%	26.3%	21.9%	11.0%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2012), the unemployment rate in Waterbury is 12.7%. This rate is higher than the unemployment rate across Connecticut (8.5%). It is favorable or comparable to peer cities. Of the residents who are employed, the majority work in management, business, science, and arts and are private wage and salary workers. A notable percentage of residents are also employed in a service occupation.

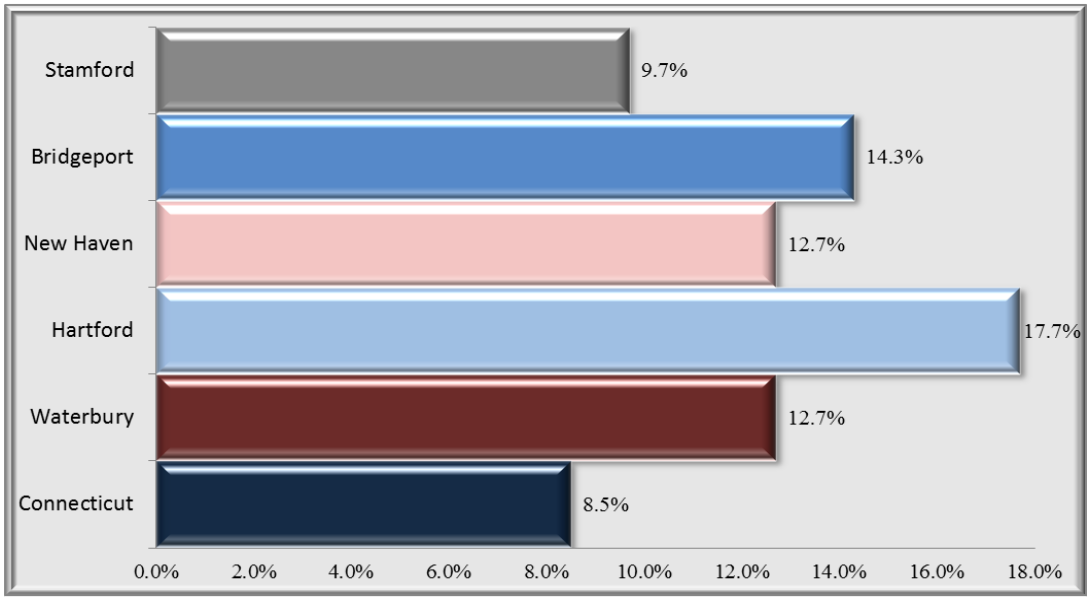


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. High school and higher education graduation rates are lower in Waterbury (78.7% and 17.2% respectively) than in Connecticut (88.6% and 35.7% respectively) and comparable to peer cities (U.S. Census Bureau, 2012).

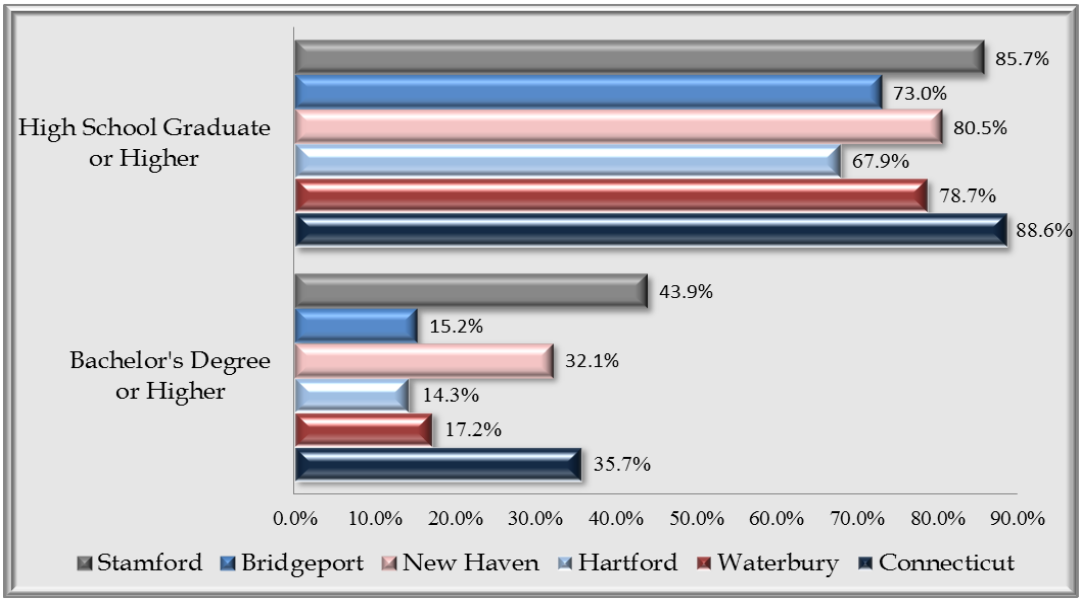


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

Health Status Indicators

Mortality Rates

The overall crude mortality rate for Waterbury, Connecticut is 9.2 per 1,000. This is higher than the mortality rate for Connecticut (8.1 per 1,000) and peer cities. A contributing factor to the higher overall mortality rate in Waterbury compared to peer cities may be its slightly older population. However, this does not apply when comparing to all of Connecticut as the state has a higher median age (Connecticut Department of Public Health, 2011).

The graphs below detail the age-adjust deaths rates per 100,000 for three of the leading causes of death in Waterbury. For all causes, Waterbury has a higher death rate than Connecticut. For chronic lower respiratory disease, Waterbury has a higher death rate (37.2) than Connecticut and all peer cities. Death rates due to heart disease and cancer in Waterbury are comparable to peer cities, but are still of concern as the top two leading causes of death (Connecticut Department of Public Health, 2011).

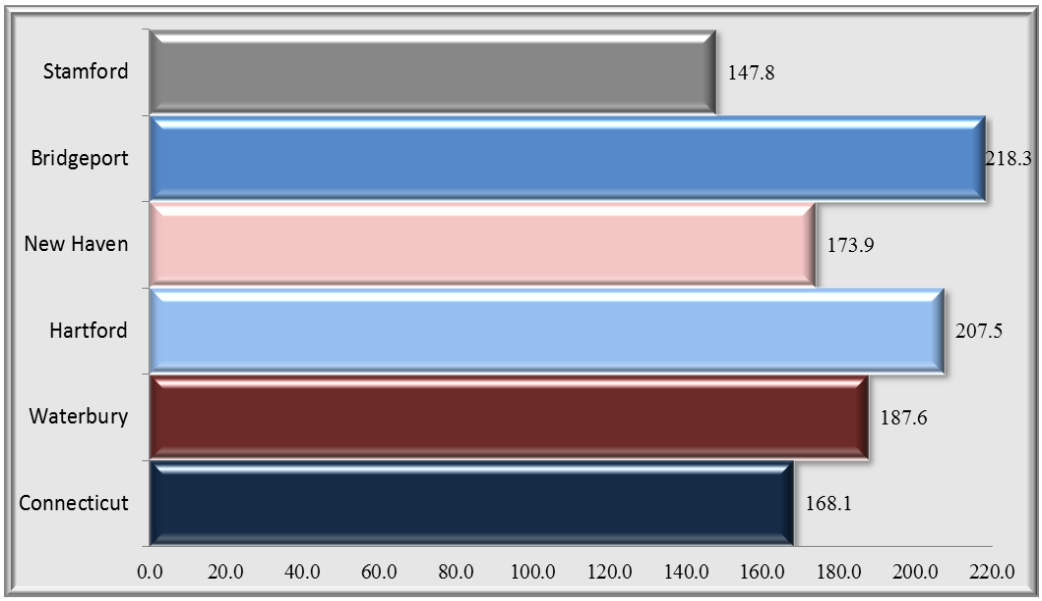


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

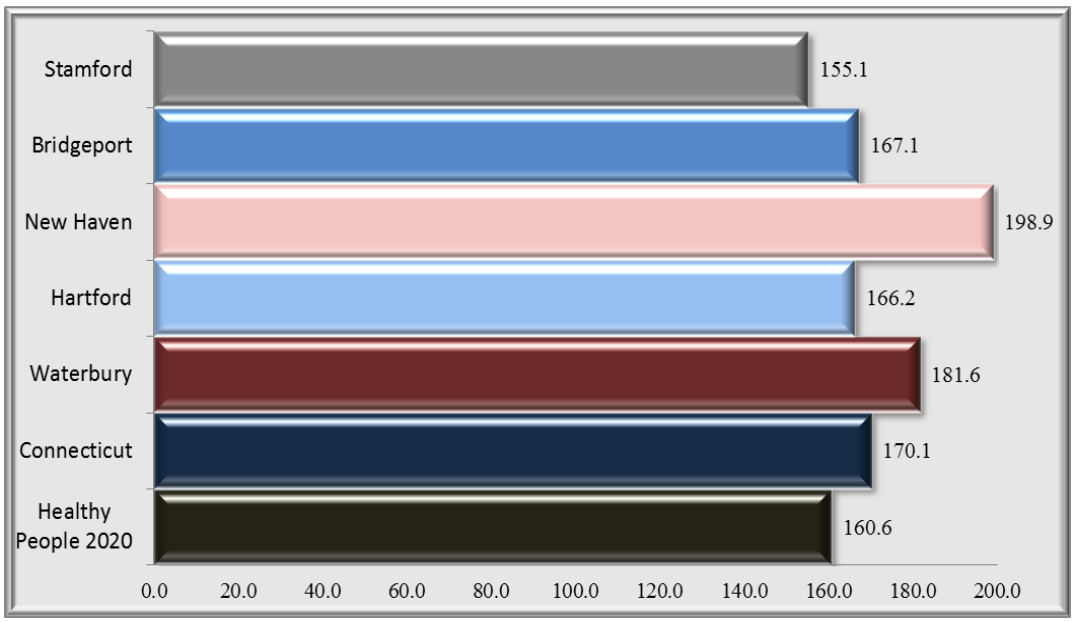


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

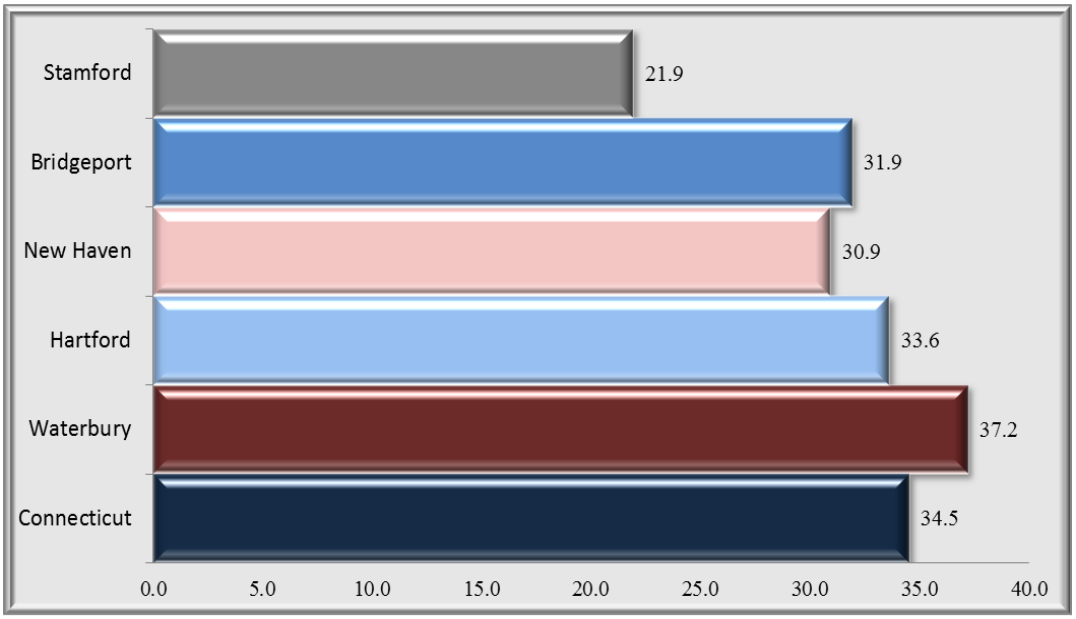


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

Maternal & Infant Health

The birth rate per 1,000 in Waterbury (15.7) is higher when compared to Connecticut (11.0), but similar to or lower than peer cities. Of the births that occur, 4.9% are to mothers less than 18 years of age and 14.5% are to mothers less than 20 years of age. These percentages are higher than what is seen across Connecticut (2.0% and 6.8% respectively) and all peer cities, excepting Hartford. The majority of teenage births are to mothers of Black and/or Hispanic race/ethnicity. Overall, the findings for teenage birth for the most recent year of data are negative, but births to teenagers less than 18 years of age have been trending downwards since 2005 (Connecticut Department of Public Health, 2011).

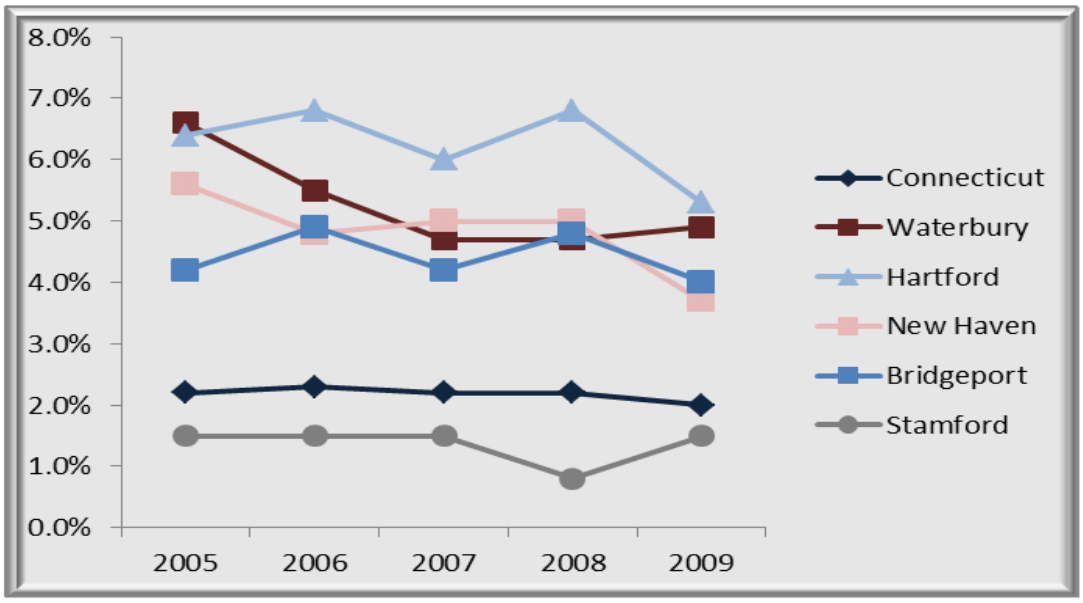


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

A total of 16 infant deaths occurred in Waterbury for a rate of 9.5 per 1,000 live births. This is higher when compared to Connecticut (5.6) and the Healthy People 2020 goal (6.0). The majority of infant deaths was among White infants (11 deaths, rate of 8.6) and occurred in the neonatal phase (within the first 27 days after birth). Seven Hispanic infant deaths also occurred in Waterbury for a rate of 10.4. This compares to a rate of 7.1 across all of Connecticut. In general, infant mortality has trended upwards in Waterbury since 2005 (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Related to infant mortality is birth weight. The percentage of infants born with low birth weight in Waterbury (10.0%) is higher when compared to Connecticut (8.1%), the Healthy People 2020 goal (7.8%), and every peer city except Hartford (10.5%). In particular, the percentage of Black infants born with low birth weight (14.6%) and very low birth weight (4.1%) is notably higher compared to Connecticut (12.0%; 3.2%) and all peer cities. Low birth weight has been on the rise in Waterbury since 2005, particularly for Black infants (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Despite primarily negative findings related to teenage birth, infant mortality, and birth weight, Waterbury mothers are more likely to receive adequate and intensive prenatal care than mothers across Connecticut. This is true for mothers of White, Black, and Hispanic race/ethnicity. Mothers receiving late or no prenatal care has been on the decline in Waterbury since 2005 (Connecticut Department of Public Health, 2011).

Sexually Transmitted Illnesses

Sexually transmitted illness rates per 100,000 are notably higher in Waterbury than in Connecticut, particularly for chlamydia and gonorrhea. The chlamydia rate is 720.5 in Waterbury compared to 344.9 in Connecticut and the gonorrhea rate is 225.9 in Waterbury compared to 72.6 in Connecticut. The Waterbury rates are more favorable compared to peer cities. The chlamydia rate alone is as high as 1,220.3 in New Haven and 1,513.8 in Hartford (Connecticut Department of Public Health, n.d.). The following chart illustrates this difference.

Table 3. Sexually Transmitted Illness Cases per 100,000 (2009, 2010)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
HIV	11.4	17.2	54.5	31.6	33.3	11.4
Gonorrhea	72.6	225.9	403.0	363.3	239.6	37.2
Chlamydia	344.9	720.5	1,513.8	1,220.3	863.8	268.5
Primary/Secondary Syphilis	1.8	1.9	6.4	3.2	4.4	2.5

Sources: Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2010 data

Mental Health Statistics

The suicide rate is considered to be an indicator of the mental health status of an area. The suicide rate per 100,000 in Waterbury is 8.6, which meets the Healthy People 2020 goal of 10.2, but is higher than Connecticut (7.8) and all peer cities (5.5 – 8.4). The suicide rate is a negative finding, but it should not be considered an all-encompassing indication of the mental health status of Waterbury. Additional indicators from the household telephone survey, focus groups, and key informant interviews should be considered for a more comprehensive understanding (Connecticut Department of Public Health, n.d. & Healthy People 2020, 2012).

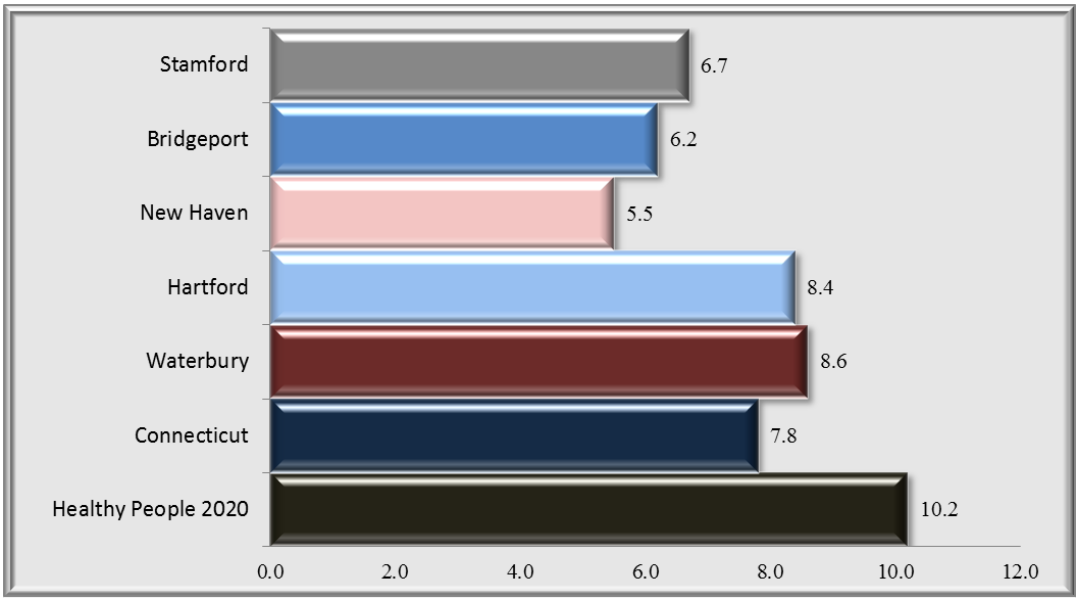


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Cancer Statistics

Cancer affects Waterbury residents at a rate of 484.3 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 484.3 is similar to or lower than that of Connecticut and peer cities. However, lung cancer disproportionately affects Waterbury residents at a rate of 81.2 compared to 74.3 across Connecticut and a range of 45.0 – 67.5 across all peer cities (Connecticut Department of Public Health, n.d.). The following chart depicts incidence rates for all reported cancer types.

Table 4. Cancer Incidence by Site per 100,000 (2007)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	155.6[a]	134.8[a]	83.7[a]	118.9[a]	107.8[a]	155.8[a]
Colorectal	51.3	51.3	33.7	37.9	43.2	65.0
Lung	74.3	81.2	45.0	55.7	64.4	67.5
Prostate	173.3[a]	76.2[a]	119.5[a]	116.8[a]	128.6[a]	178.8[a]
All sites	**561.6**	**484.3**	**335.6**	**445.4**	**443.3**	**534.3**

Source: Connecticut Department of Public Health, n.d.
[a]Rates based on 2010 population counts

In contrast to the overall cancer incidence rate, the overall cancer mortality rate is higher in Waterbury than in Connecticut and all but one peer city, New Haven. The mortality rate per 100,000 for all cancer types is 181.6 in Waterbury compared to 170.1 across Connecticut and a range of 155.1 – 167.1 across Bridgeport, Stamford, and Hartford. Lung cancer presents as an area of concern again as the mortality rate for this condition is notably higher in Waterbury

(53.5) compared to Connecticut (45.0), Healthy People 2020 (45.5), and all peer cities (36.5 – 44.1) (Connecticut Department of Public Health, n.d.).

Table 5. Cancer Mortality by Site per 100,000 (2005 - 2009)

	HP 2020	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	20.6	N/A	12.8	11.0	17.9	14.5	11.7
Colorectal	14.5	14.6	15.9	16.4	18.5	13.8	12.8
Lung	45.5	45.0	53.5	42.2	44.1	43.3	36.5
Prostate	21.2	N/A	7.7	8.9	11.8	7.2	9.1
Skin	N/A	2.6	N/A	N/A	N/A	N/A	N/A
All sites	160.6	170.1	181.6	166.2	198.9	167.1	155.1

Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Environmental Health Statistics

The environment that residents live, work, and play in can have a profound impact on their health. An indicator of the environmental health of an area is the prevalence of asthma. In Waterbury, the rate per 100,000 for emergency department visits due to asthma is 144.0 in adults 18 years and over and 197.3 in children under 18 years. This is notably higher than Connecticut's rates for adults and children (44.7 and 61.3 respectively) and most peer cities. Among adults in Waterbury, females, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma. Among children in Waterbury, males, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma (Connecticut Department of Public Health, 2009).

Table 6. Emergency Department Visits due to Asthma per 10,000 (2001 – 2005)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Population 18 +	44.7	144.0	182.8	108.8	126.7	41.5
Population <18	61.3	197.3	241.7	213.8	165.9	80.8

Source: Connecticut Department of Public Health, 2009

Another indicator of the environmental health of an area is the presence of food deserts, which are defined by Census tracts. Food deserts are areas that have little or no access to fully-stocked grocery stores that offer fresh, healthy, and affordable foods. In Waterbury, a number of census tracts have large populations living in food deserts. However, census tract 9009352400 is of particular concern. It has the highest percentage of residents living in a food desert across four out of the five reported categories (United States Department of Agriculture, 2010).

Table 7. Food Deserts by Census Tracts in Waterbury, Connecticut (2012)

	Population with low access to nutritious food sources	Population with low income and low access	Population 0-17 years with low access	Population 65+ years with low access	Population with no vehicle and low access
9009352400	100.0%	12.7%	31.6%	9.7%	16.4%
9009352300	21.3%	2.5%	5.2%	2.5%	3.4%
9009352200	55.1%	18.5%	24.2%	2.9%	14.2%
9009352100	33.7%	5.4%	9.5%	4.7%	3.6%
9009351800	57.7%	3.6%	10.8%	9.5%	3.7%
9009351500	45.9%	5.6%	11.7%	7.4%	7.0%
9009352800	33.4%	2.8%	11.4%	2.4%	4.3%

Source: United States Department of Agriculture, 2010

Secondary Data Profile Summary of Findings

The secondary data profile provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. In Waterbury, the median income for households and families is higher; fewer residents live in poverty when compared to most peer cities. Residents are also less likely to rely on social assistance programs like Medicaid and State Administered General Assistance medical. In terms of health outcomes, Waterbury has lower rates of stroke mortality and sexually transmitted illness incidence. Waterbury has a number of strengths and assets, but it also has some areas to improve upon. In particular, Waterbury residents have more respiratory health issues and issues related to maternal and child health. In relation to respiratory health, residents are more likely to have visited an emergency department for asthma complications and to have died from lung cancer and chronic lower respiratory disease. Related to maternal and child health, the infant mortality rate is higher, infants are more likely to be born with low or very low births weight, and the number of teenage pregnancies is higher. Additional areas of concern in Waterbury are the suicide rate and food deserts, particularly in census tract 9009352400.

HOUSEHOLD TELEPHONE SURVEY OVERVIEW

Background

A statistical Household Telephone Survey was conducted based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, conducted annually at the state level. The survey assesses self-reported health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

For the Waterbury study, trained interviewers conducted telephone interviews between May and June 2013 by trained interviewers. Participants were randomly selected for participation based on a statistically valid sampling frame that included landline and cell phone telephone numbers. Only respondents who were at least 18 years of age and lived in a private residence were included in the study. A total of 1,121 individuals who reside within specific Zip codes served by the Greater Waterbury Health Improvement Partnership were interviewed by telephone. Select participant demographics are included in Appendix C.

The customized survey tool consisted of approximately 100 factors selected from BRFSS tool. A few customized questions were added to gather information about health issues specific to the service area. Depending upon interviewees' responses, interviews ranged from approximately 15 to 30 minutes in length.

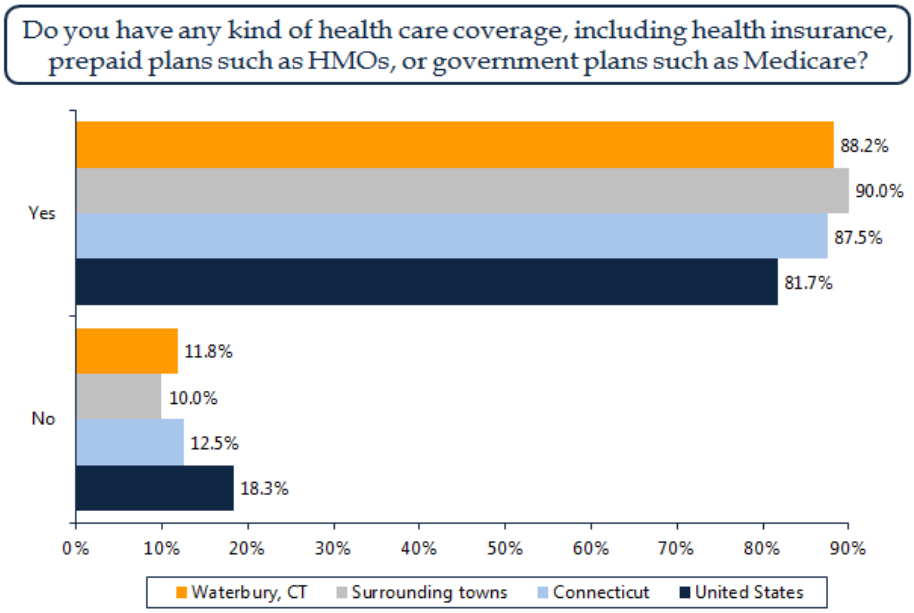
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

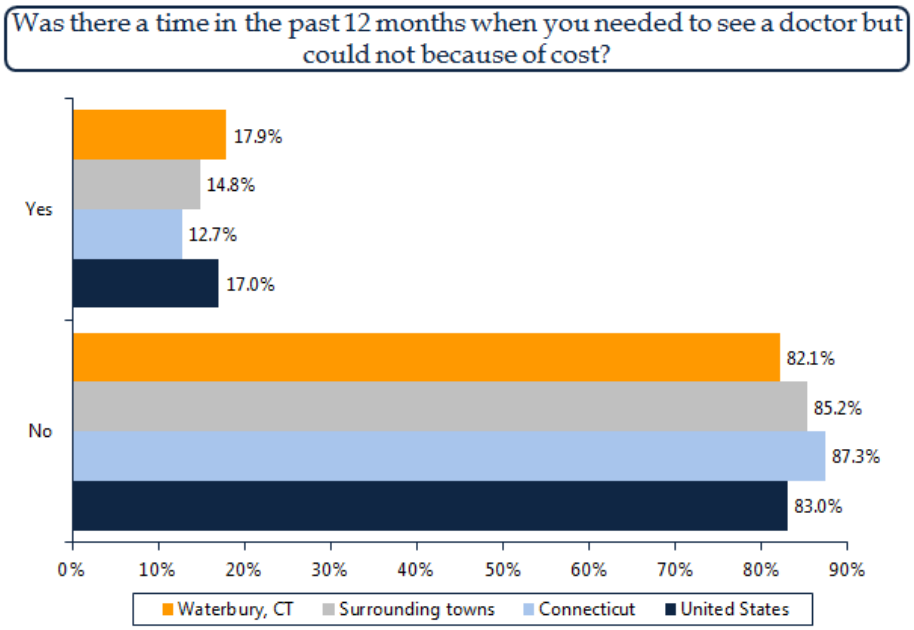
Household Telephone Survey Key Findings

The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

Access to Health Care

Overall, residents of Waterbury are just as likely or more likely to have health care coverage (88.2%) and at least one person who they think of as their personal doctor or health care provider (84.1%) when compared to the state (87.5%; 85.2%) and the nation (81.7%; 78.0%). Local residents are also more likely to have received a routine checkup within the past year (76.6%) compared to the state (70.4%) and the nation (66.9%). Despite primarily positive findings regarding health insurance and access to primary care, residents of Waterbury still cite the cost of care as a barrier. Nearly 18% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This may be an indicator that out-of-pocket expenses that are not covered by insurance (e.g. copays) are preventing residents from seeking care when they need it.

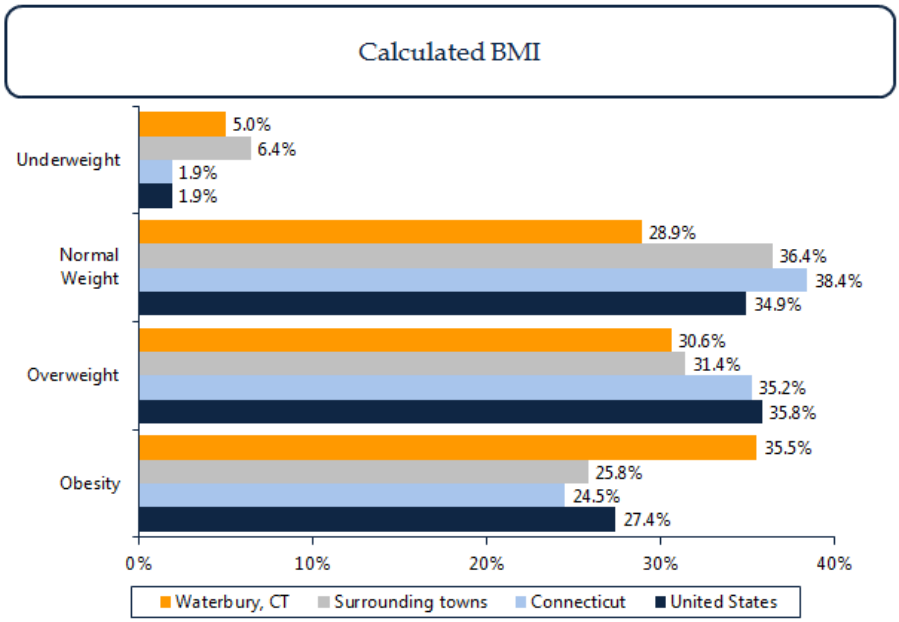




Health Risk Factors

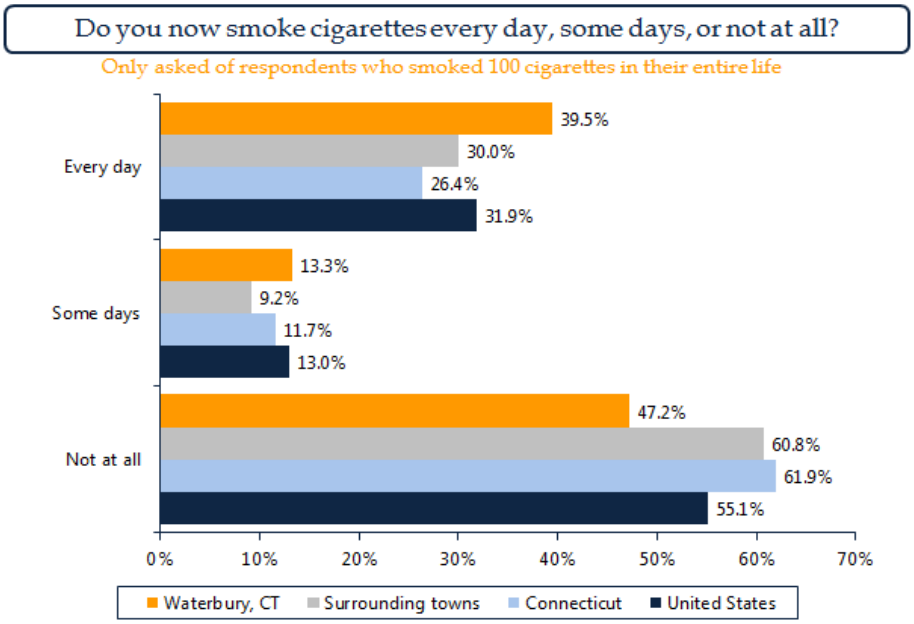
Obesity & Physical Activity

Obesity and its connection to serious medical conditions has become a national concern. In the latest BRFSS study, 63.2% of the nation and 59.7% of Connecticut was considered overweight or obese. Waterbury surpasses both with 66.1% of respondents considered overweight or obese and 35.5% considered obese. In addition, fewer respondents (68.9%) reported engaging in physical activity during the past month compared to the state (74.5%) and the nation (74.3%).

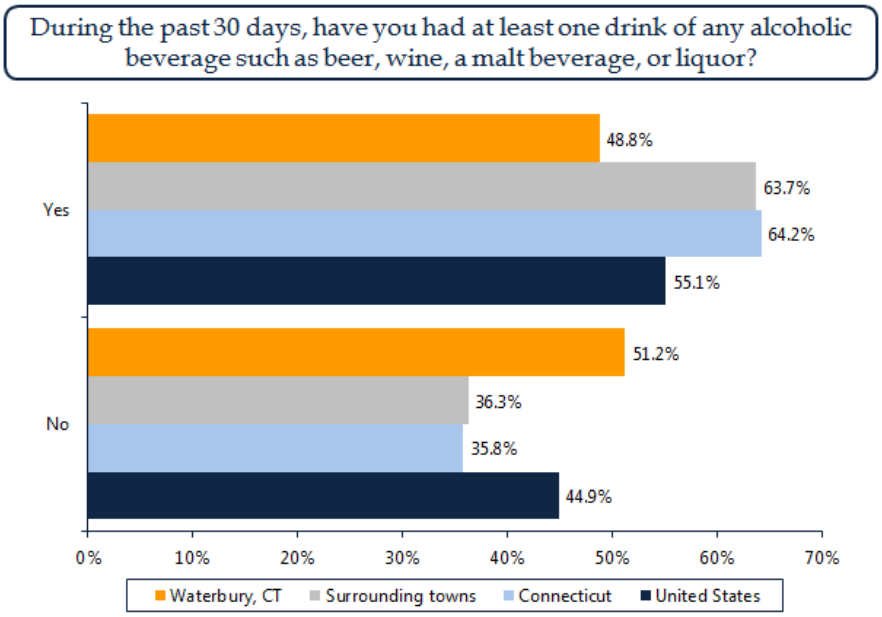


Tobacco & Alcohol Use

Tobacco use is a concern in Waterbury for both the proportion of residents who initiate smoking and the proportion who continue to smoke on a daily basis. More than half (51.1%) of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 45.0% across the state and 44.8% across the nation. In addition, more than half (52.8%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (38.1%) and the nation (44.9%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months.



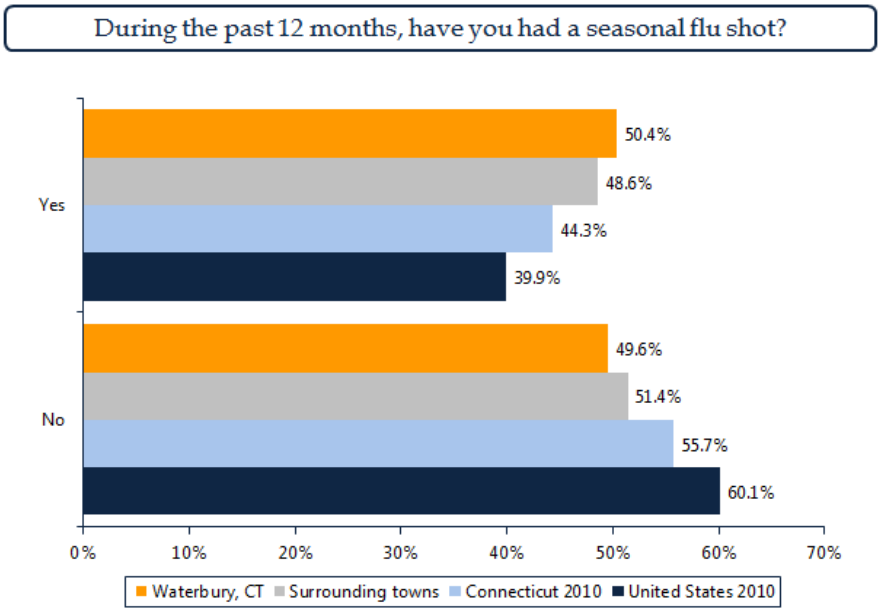
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.



Preventive Health Practices

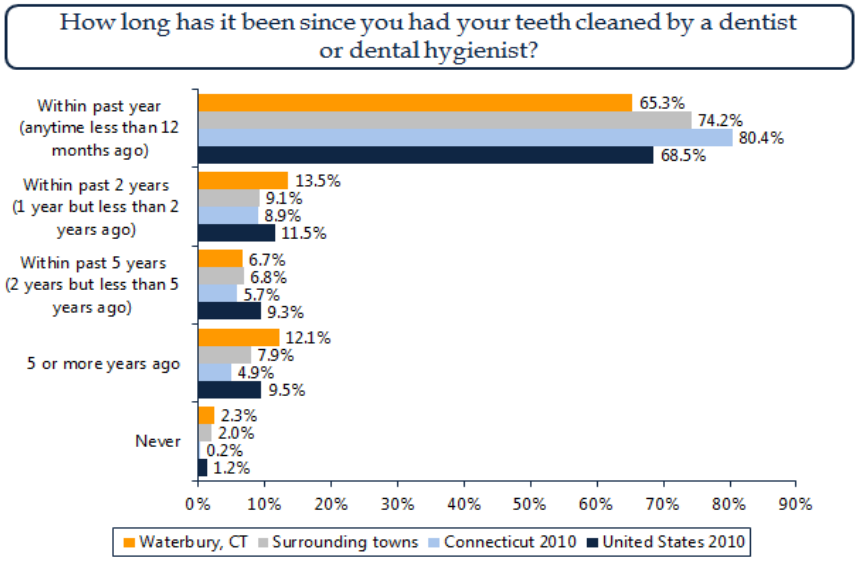
Immunizations

A positive finding among Waterbury respondents is the prevalence of immunizations. In the past 12 months, 51.8% of respondents received a flu vaccine either as a shot or a nasal spray compared to 45.2% in Connecticut and 41.3% in the nation. In addition, 35.5% received a pneumonia shot compared to 30.9% in Connecticut and 30.6% in the nation.

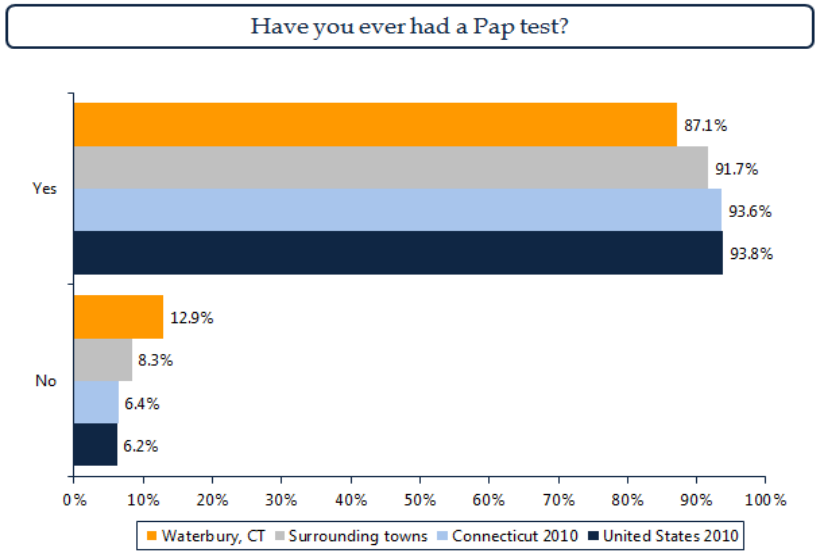


Screenings

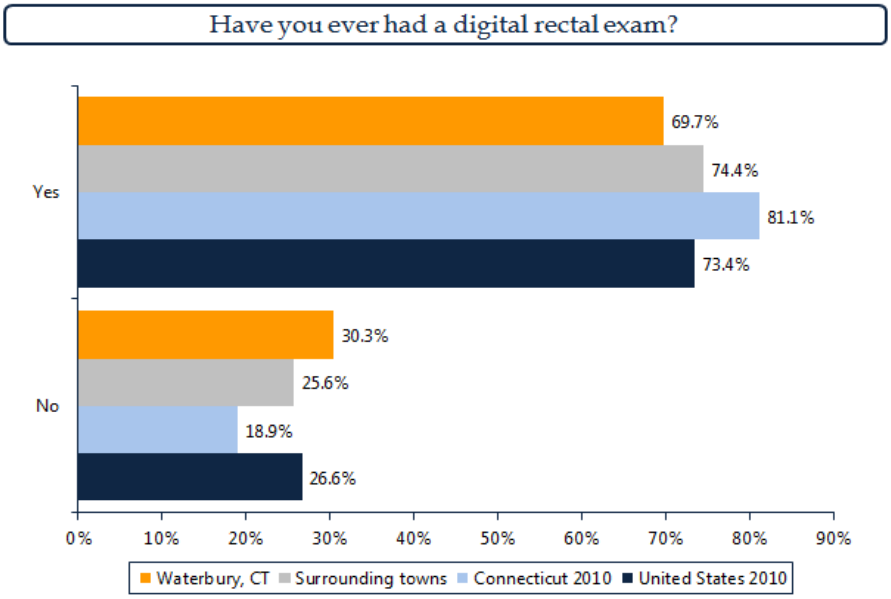
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents are also less likely to have had their teeth cleaned (65.3%) within the past year when compared to both the state (80.4%) and the nation (68.5%).



Female preventative screenings are also less prevalent among Waterbury residents. Women are less likely to have ever received a mammogram, clinical breast exam, or Pap test when compared to women across Connecticut and the nation. The percentage of Waterbury women receiving a Pap test is of particular concern as only 87.1% have ever had one compared to 93.6% in Connecticut and 93.8% in the nation. The percentage of women receiving clinical breast exams (87.8%) is also concerning when compared to all of Connecticut (92.4%).



Men ages 39 and older have a greater risk for prostate cancer and should receive regular diagnostic screenings. Male respondents in Waterbury are more likely to have had one of the suggested screenings, a prostate-specific antigen test (57.5%), when compared to men across the nation (51.1%). However, they are less likely to have the second suggested screening, a digital rectal exam (69.7%), when compared to men across Connecticut (81.1%) and the nation (73.4%). In addition, of the men who have had a digital rectal exam, fewer had it within the past year. This is a potential health concern since male respondents in Waterbury are more likely to have prostate cancer (6.0%) when compared to the nation (3.5%).



Colorectal cancer can be screened for through home blood stool tests and sigmoidoscopies/ colonoscopies. Waterbury respondents are slightly more likely to have had a sigmoidoscopy/ colonoscopy when compared to the nation, but notably less likely to have had a home blood stool test (27.7%) when compared to the nation (45.4%). Of those respondents who have had a home blood stool test, a large proportion last had one five or more years ago (35.0%).

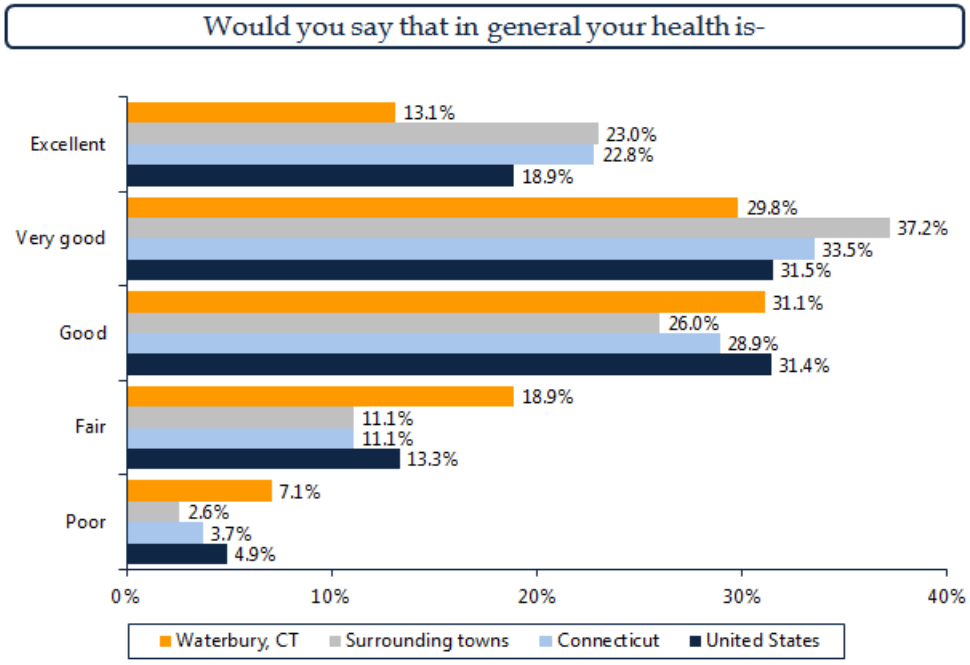
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high risk behaviors. Approximately 7% of Waterbury respondents said that high risk situations like intravenous drug use and sexually transmitted diseases apply to them. This compares to 3.6% across Connecticut and 3.8% across the nation.

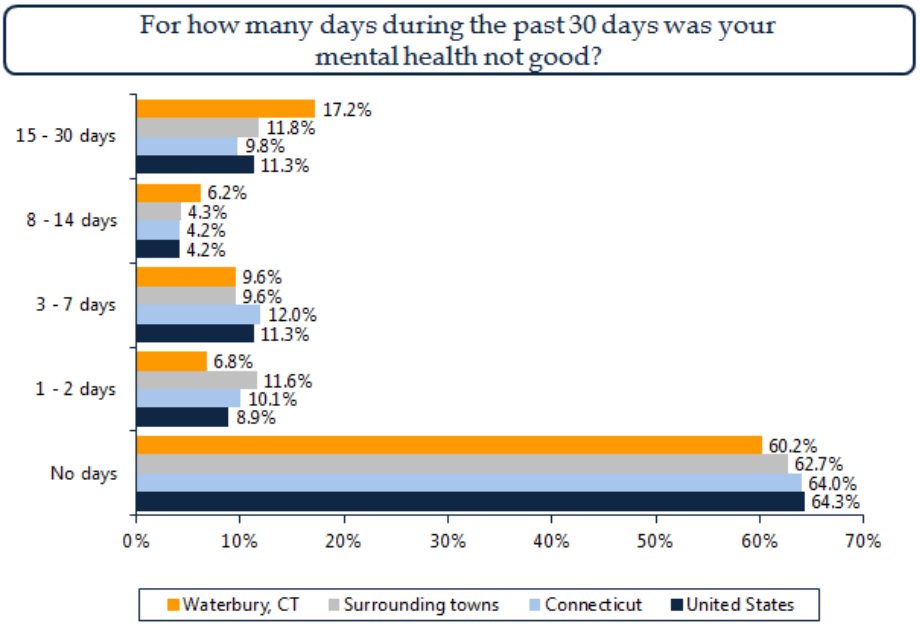
Health Status & Chronic Health Issues

Physical & Mental Health

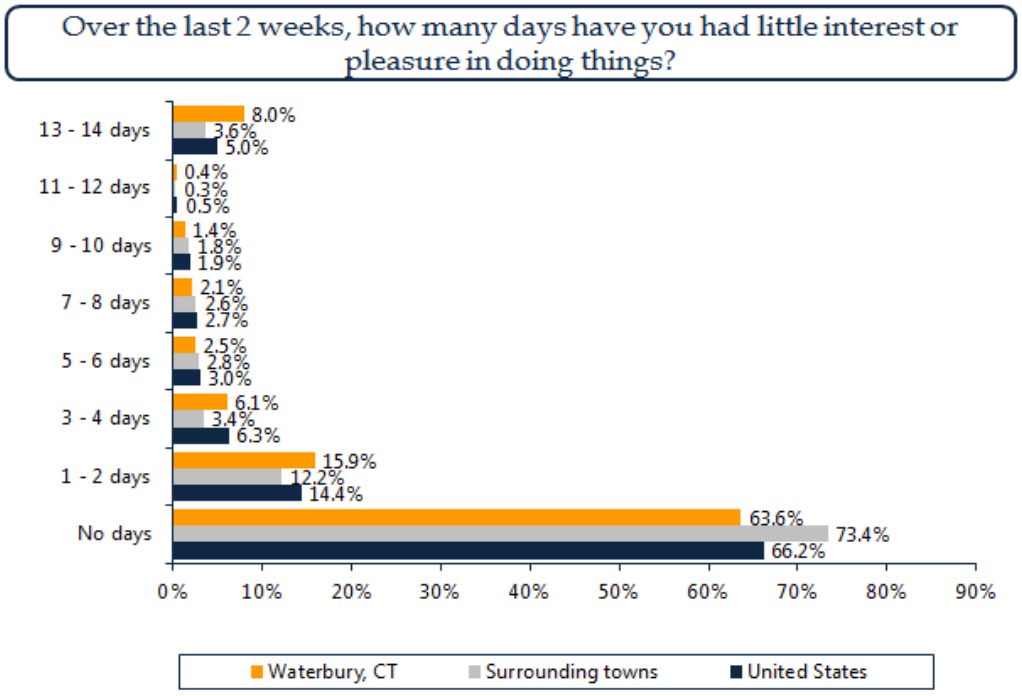
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

the nation (18.9%). In addition, during the past 30 days, 40.8% of respondents said that they had at least one day of poor physical health and 39.8% said that they had at least one day of poor mental health. Of particular concern is the 17.2% of respondents who said that they had 15 – 30 days of poor mental health during the past 30 days. This compares to 9.8% across Connecticut and 11.3% across the nation. The combination of poor physical and mental health days kept 45.3% of respondents from doing their usual activities on at least one of the past 30 days.





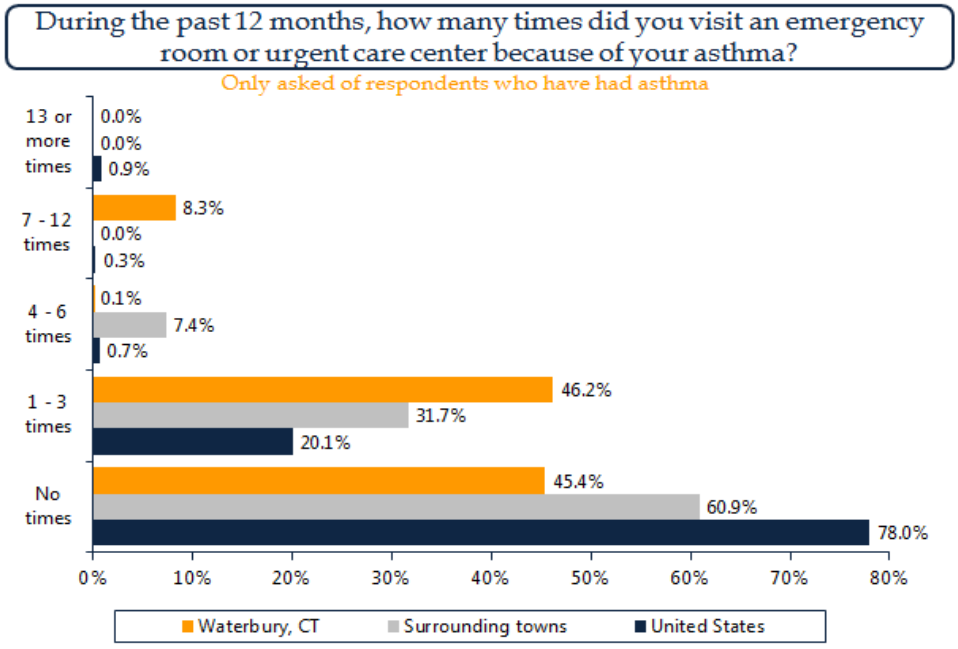
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 19.7%. This compares to 16.7% across the nation. Over the last two weeks, 36.4% of respondents had little interest or pleasure in doing things and 34.3% felt down, depressed, or hopeless. A positive finding is that more respondents (16.4%) are taking medicine or receiving treatment from a health professional for their mental health condition when compared to the nation (12.5%).



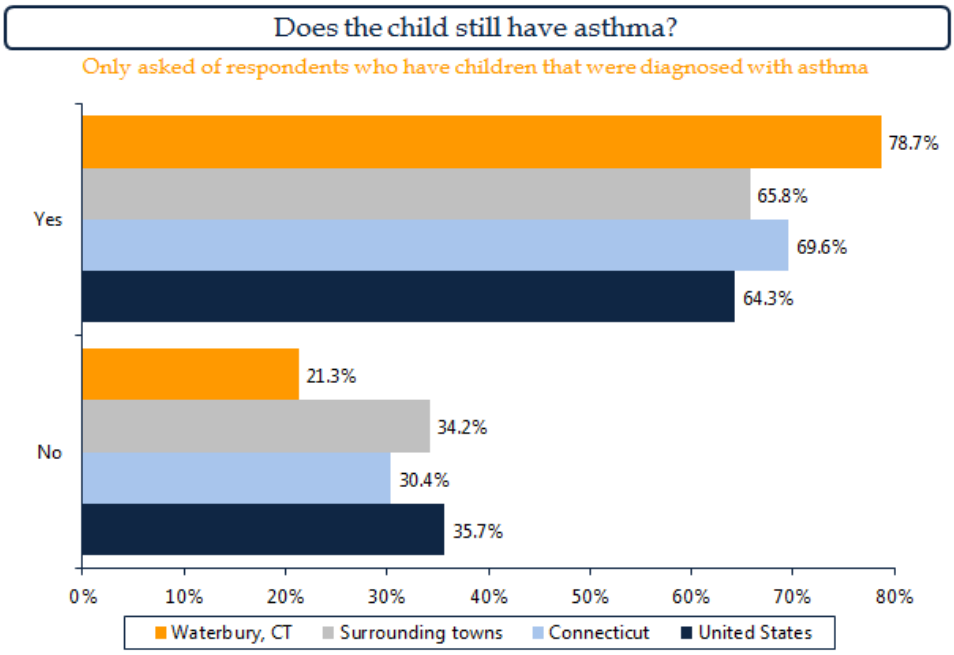
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the nation.

Chronic Health Issues

A number of chronic conditions are of concern in Waterbury, including asthma, cardiovascular disease, and diabetes. Approximately 22% of Waterbury respondents had been told that they have asthma. This compares to 14.8% in Connecticut and 13.5% in the nation. Additional data also suggests that asthmatics in Waterbury are not managing their condition as well. A higher proportion have had an asthma attack (59.2%) and visited an emergency room or urgent care center in the past year (54.6%) when compared to the nation (43.0%; 22.0%). A higher proportion has also been unable to carry out their usual activities because of their asthma (39.5%) when compared to the nation (23.8%).

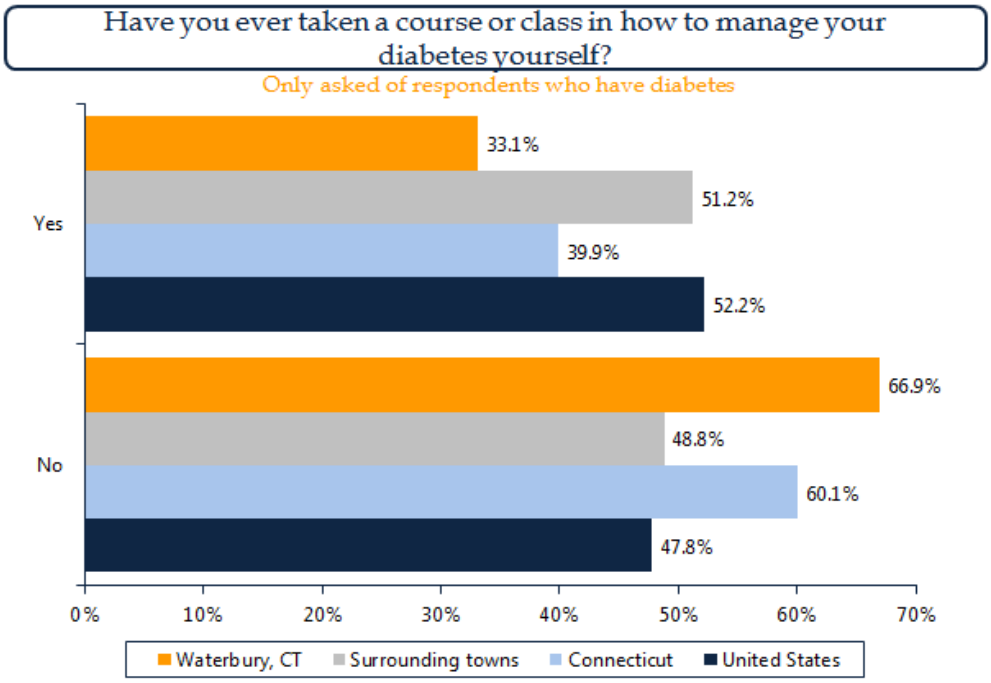


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



Residents in Waterbury are more likely to have cardiovascular health issues like heart attacks (6.6%), angina or coronary heart disease (5.9%), and stroke (5.4%). A contributing factor (other than obesity and lack of physical activity) may be high blood pressure. A higher proportion of Waterbury residents have high blood pressure (33.6%) when compared to Connecticut (29.7%) and the nation (31.6%) and fewer are taking medicine for it.

A higher proportion of residents in Waterbury have been diagnosed with diabetes (14.8%) when compared to Connecticut (9.3%) and the nation (9.8%). This is a concern for the community in terms of prevention, but even more concerning is that diabetics in Waterbury are less likely to manage their condition. Fewer diabetics are taking insulin, checking their blood glucose levels on a daily basis, seeing a health professional for their condition, having a health professional conduct an A1C test or foot check, and attending self-management courses. Specifically, only 33.1% of diabetic respondents have taken a course in how to manage their diabetes compared to 39.9% of diabetics across Connecticut and 52.2% of diabetics across the nation.



Household Telephone Survey Summary of Findings

A number of areas of opportunity were identified through the household telephone survey. The first area was access to care. Residents are more likely to have trouble affording out-of-pocket expenses despite having equitable health insurance coverage. They are also less likely to receive preventive screenings related to oral health and women's health. The second area was chronic health conditions. Respiratory conditions presented as an issue with a higher proportion of residents saying that they and their children have asthma. A contributing factor to asthma rates may be the proportion of residents who smoke cigarettes. Cardiovascular disease and diabetes

also presented as concerns among residents. Contributing factors to these conditions may be the proportion of residents who are overweight or obese and have high blood pressure. The third area was the mental health status of Waterbury. Residents have more days of poor mental health, are more likely to experience depression and be diagnosed with an anxiety disorder.

FOCUS GROUPS OVERVIEW

Background

A total of six focus groups were held at various locations throughout Waterbury in February 2013. Two of the groups were conducted with health care providers associated with the two hospitals; four groups were conducted with members of neighborhood associations. Focus group topics addressed access to care, cultural competency, physical activity, nutrition/healthy eating habits, weight/obesity, and health information. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through the CHNA partners. In exchange for their participation, health care providers were given a $25 gift card; community members received $25 cash. Two discussion guides developed in consultation with the Greater Waterbury Health Improvement Partnership, were used to prompt discussion and guide the facilitation.

In total, 57 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of providers and community members and may not necessarily represent all providers and residents of Waterbury.

The following section provides a summary of the focus group discussions including key themes and select comments.

Health Care Provider Focus Groups Key Findings

Access to Care

Access to care was an area of shared concern among Saint Mary's and Waterbury Hospital physicians. Physicians agreed that the greatest barriers to accessing care in Waterbury are an inadequate number of physicians, particularly primary care physicians, and health insurance-related issues. The primary care shortage in Waterbury has prohibited patients from having assured and timely access to care, even if they are insured. Many patients with medical homes are still using the ED due to the limited hours of clinics and the overwhelming demand for limited appointment slots. Participants also pointed out that primary care physicians are the lowest paid providers and care for the most challenging payer mix.

Participants shared that low Medicaid reimbursements limit the number of patients that primary and specialty physicians are willing to see. One physician stated, "It costs us more to see the

patients than what we receive in reimbursement." Additional barriers to accessing care included a lack of awareness of available services among eligible patients, limited bilingual services for non-English speaking residents, transportation, and co-payments. Another physician stated, "Even residents with health insurance are financially stressed and don't follow through on their care due to copayment costs."

There was general consensus among providers that patients with mental and/or behavioral health issues are underserved. It is difficult for these patients to receive the care that they need because providers are hesitant to "take responsibility for them" and services are limited. Providers are reluctant to be the "physician of record." Other underserved populations included the seasonally insured, service industry workers, and minority populations.

Participants listed a number of resources for uninsured and underinsured residents. The Waterbury Health Access Program (WHAP) was seen as particularly successful in linking needy patients with volunteer physicians and insurance. Lack of funding could jeopardize the future of the program.

Key Health Issues and Challenges

Mental and behavioral health issues were seen as key health issues in the community. One physician suggested that there was "widespread emotional despair" within the city. Other concerns were that elderly patients suffered from dementia, late-stage breast cancer diagnoses, and obesity.

Related to obesity, participants saw a number of challenges for residents trying to stay physically fit and eat a healthy diet. Fresh fruits are expensive and not widely available following recent closings of several supermarkets. An increase in farmers' markets was seen as a positive development. Other barriers included residents' awareness of healthy diets, as well as their willingness to dedicate resources to costly fruits and vegetables (over less expensive fast food alternatives). Compounding challenges to maintaining health, a lack of accessible, safe recreational areas was noted.

Participants provided several recommendations for improving the health of the community. Better patient navigation, extended clinic hours to serve residents instead of the ED, and higher reimbursement for Medicaid patients, were among recommendations provided. Participants agreed that mental health treatment options also needed to be expanded. Investments to improve poor economic conditions in the city needed to continue.

Provider Resources

Providers agreed that insurance-related issues are one of the top obstacles that they face in providing care. The amount of paperwork required by each plan burdens medical offices and takes away from direct patient care. Providers also stated that a merger between the two hospitals in Waterbury would create more seamless care and financial stability that would allow for more modern technology.

Local health departments were viewed as helping to meet the needs of the Waterbury community; however, most participants were not aware of specific activities. The general consensus was that more support from entities across the community was needed. One participant stated, "It comes down to shared responsibility. Everyone needs to take a part."

Community Resident Focus Groups Key Findings

Access to Care

A number of issues were identified by community residents as barring people from accessing health care. Many issues were centered on the cost of care. Participants identified lack of health insurance, the cost of copayments and medications, and increasing premiums and deductibles, specifically. They also expressed concern that Husky Care (Medicaid) was often not accepted by providers and that people were "looked down upon" for having it. Other issues included transportation, clinic hours of operation, language barriers, lack of awareness of services, and legal status. Participants stated that it can "take all day" to see the doctor due to the limited number of bus stops and long wait times between rides. They also stated that the only place to receive care after hours was the ED since clinics and private medical offices were closed. Hispanics/Latinos and Albanian residents were viewed as most impacted by language barriers.

Participants felt that a number of populations within the community were not being adequately served by local health services. These included African Americans, Hispanics/Latinos, single mothers with children, the homeless, mentally ill residents, seniors, and teens. Participants explained that for those seniors who need assistance with Activities of Daily Living (ADL), traveling to the Veteran's Administration Hospital in West Haven (45 minutes away) is a burden. They also expressed that teens are often not able to afford medication and are struggling with issues like sexually transmitted diseases. Resources identified that cared for underserved populations included hospital EDs, health clinics, Planned Parenthood, and the Malta House of Care van.

Dental care and mental health care were viewed as lacking services in the community. Participants agreed that dental care is largely unavailable without insurance. There was general consensus that there was "no place to go" for mental health care services. One person stated, "You have to commit a crime to get mental health care."

Key Health Issues and Challenges

More than 10 health issues were identified as major concerns in the community. Among the issues, mental and behavioral health issues were mentioned several times. In particular, participants noted wide-spread abuse of medicines like Nyquil and addictions to pain medication. Several factors were seen as contributing to addictive behavior including long delays in getting appointments and automatic refilling of pain medication prescriptions. Participants also noted tobacco use as a major concern. They observed that "Everyone smokes

cigarettes." An increased popularity of small cigars due to the lower cost compared to cigarettes was noted.

Participants noted a number of challenges for people in the community trying to stay physically fit and eat healthier. There was broad agreement that Waterbury does not offer adequate opportunity for physical activity. Comments included: "There are no safe parks." "Sidewalks are not in good condition." "Streets are of an old design; they are not wheelchair or stroller friendly." "There are no bike trails." "Today's parks have crooked slides and broken sprinklers." "There are syringes on the ground."

Programs that are available for recreation have a cost associated with them. Two organizations, the Police Athletic League (PAL) and the YMCA, were seen as positive entities, although both have fees for participation. Participants agreed that fresh fruits and vegetables were available year-round, but that barriers like cost, transportation, and location keep residents from accessing them widely. The farmer's market was seen as a step in the right direction; however, one participant said "You have to fight your way through panhandlers and the homeless to shop there." One solution was to increase the number of community gardens in Waterbury.

A number of weaknesses related to the socio-economic and physical environment of the community were identified. Participants stated that there was a lack of jobs in the area and that youth didn't have work opportunities. Poverty conditions often caused parents to "hop from apartment to apartment" to avoid paying rent, causing school transfers and disruption to children's education. Blight, littering, and poor school conditions were also concerns. One participant stated, "Residents are not invested in the areas where they live."

Community Aspirations & Capacity

Participants offered a number of suggestions for improving the health of the community. Specific examples included expanding access to care by "bringing back" the StayWell Health Center van; sponsoring free dental clinics; offering more health screenings and smoking cessation programs; and promoting on-going health education campaigns. Cleaning up the city park, improving the transportation system, sponsoring more community gardens, and providing safe and clean public restrooms in the downtown area were suggested to improve the city environment.

Participants urged community organizations to concentrate on the city as a whole and work to improve the socio-economic factors burdening residents. They also cited the need for more general counseling services and community mentors for the youth. Participants thought that efforts needed to be made to "instill more pride in the city" in an effort to encourage more community involvement and advocacy. Religious organizations were seen as untapped resource in these efforts.

Focus Group Summary of Findings

The focus group participants were grateful for the opportunity to share their thoughts and experiences; many expressed support for community-wide efforts to improve the health status of Waterbury. Identified community strengths included area healthcare providers, specifically the hospitals, health clinics, and local health departments. Areas of opportunity included expanding access to care for residents, availability of resources to improve physical activity and healthy eating, and concerns of blight and community investment.

KEY INFORMANT INTERVIEWS OVERVIEW

Background

An online survey was conducted among area "Key Informants." Key informants were defined as community stakeholders with expert knowledge including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders.

Holleran staff worked closely with the Greater Waterbury Health Improvement Partnership to identify key informant participants and to develop the Key Informant Survey Tool. Two-hundred and five (205) completed surveys were collected between February and April 2013. A listing of key informant participants can be found in Appendix D.

The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within Waterbury.

Key Informant Study Findings

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top health issues that they perceived as being the most significant. The issues that were most frequently selected were:

1. Mental/Behavioral Health
2. Overweight/Obesity
3. Access to Health Care/Uninsured/Underinsured
4. Substance Abuse/ Alcohol Abuse
5. Heart Disease

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top five issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top five. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant of their top five.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Mental/Behavioral Health	78%	32%
2	Overweight/Obesity	66%	14%
3	Access to Health Care/ Uninsured/Underinsured	63%	26%
4	Substance Abuse/Alcohol Abuse	61%	7%
5	Heart Disease	42%	5%
6	Diabetes	41%	2%
7	Cancer	34%	7%
8	Caregiver Needs	30%	4%
9	Dental Health	21%	0%
10	Tobacco	20%	1%
11	Maternal/Infant Health	16%	1%
12	Stroke	11%	1%
13	Sexually Transmitted Diseases	7%	0%
14	HIV/AIDS	6%	1%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top five.

"What are the top 5 health issues you see in your community?"

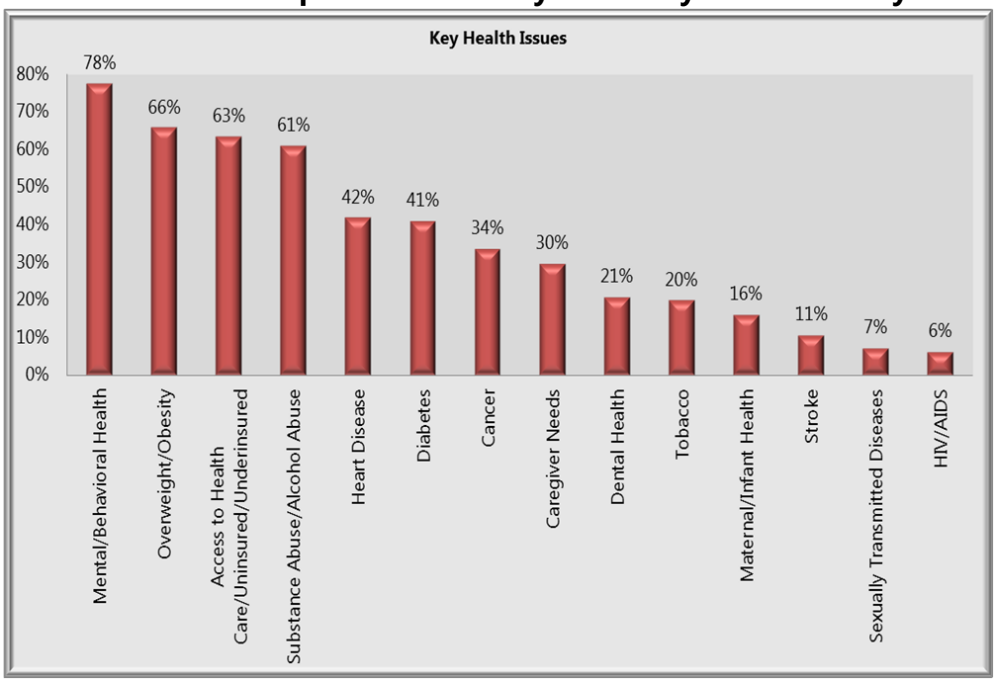


Figure 1: Ranking of key health issues

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in Table 2.

Health care access appears to be a significant issue in the community. As illustrated in Table 2, none of the informants strongly agree to any of the health care access factors. Most respondents 'Disagree', with community residents' ability to access care. Availability of mental/ behavioral health providers garnered the lowest mean responses (2.06), compared to the other factors.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access."

Table 2: Mean Responses for Health Care Access Factors

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.19	Neither agree nor disagree
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.90	Disagree
Residents in the area are able to access a dentist when needed.	2.93	Disagree
There are a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.33	Disagree
There are a sufficient number of bilingual providers in the area.	2.40	Disagree
There are a sufficient number of mental/ behavioral health providers in the area.	2.06	Disagree
Transportation for medical appointments is available to residents in the area when needed.	2.53	Disagree

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Inability to Pay Out-of-Pocket Expenses (co-pays, prescriptions, etc.)
- Lack of Health Insurance Coverage
- Inability to Navigate Health Care System

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. The third column in the table depicts the percentage of respondents that rated the barrier as being the most significant facing the community.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue	Percent of respondents who marked it as the most significant barrier
1	Inability to Pay Out of Pocket Expenses	151	80%	19%
2	Lack of Health Insurance Coverage	135	71%	20%
3	Inability to Navigate Health Care System	131	69%	26%
4	Lack of Transportation	107	57%	4%
5	Language/Cultural Barriers	86	46%	1%
6	Basic Needs Not Met (Food/Shelter)	80	42%	8%
7	Time Limitations	82	43%	3%
8	Availability of Providers/Appointments	80	42%	14%
9	Lack of Child Care	45	24%	1%
10	Lack of Trust	42	22%	2%

Figure 2 shows a graphical depiction of the frequency of selected barriers to health care access.

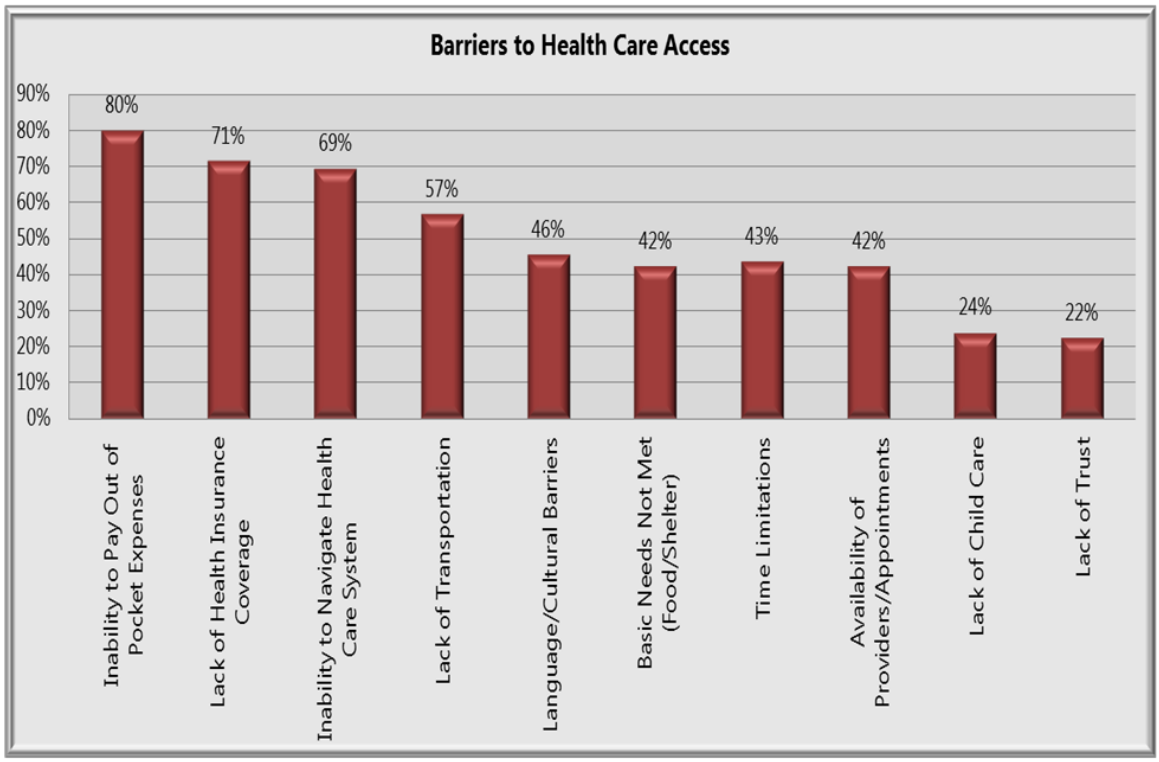


Figure 2: Ranking of barriers to health care access

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 3, the majority of respondents (82%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

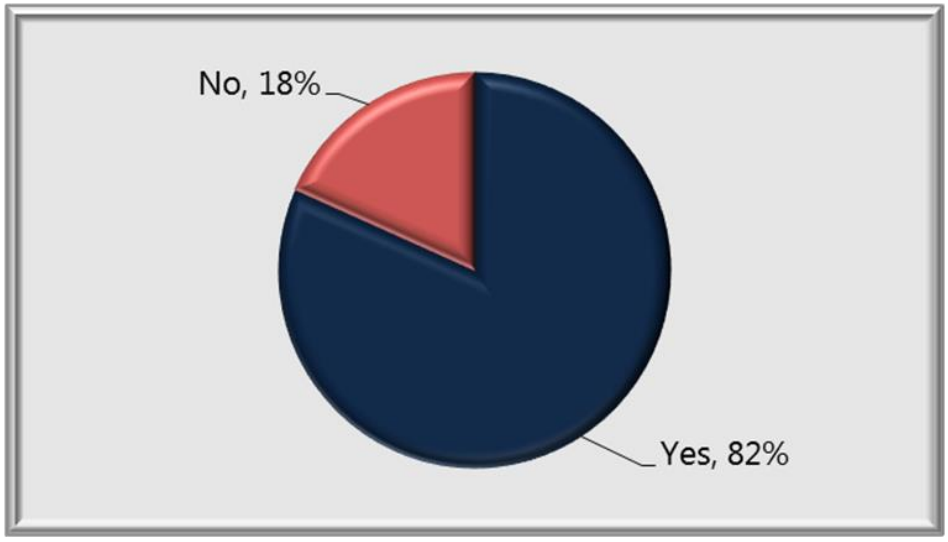


Figure 3: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Uninsured/underinsured and low-income/poor individuals were considered underserved populations along with homeless individuals and seniors/aging/elderly individuals. In addition, several respondents felt that racial/ethnic minorities and immigrant/refugee population were underserved.

Table 4: Underserved Populations

	Underserved population	Number of respondents selecting the population
1	Uninsured/Underinsured	98
2	Low-income/Poor	82
3	Homeless	64
4	Seniors/Aging/Elderly	41
5	Hispanic/Latino	35
6	Immigrant/Refugee	33
7	Black/African-American	31
8	Children/Youth	29
9	Disabled	28
10	Young Adults	22
11	Lower Middle Class	3
12	Mental Health/Addicts	1
13	Veterans	1
14	LGBT	1

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. As shown in Figure 4, the majority of respondents (81%) indicated that uninsured and underinsured individuals go to the Hospital Emergency Department for medical care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

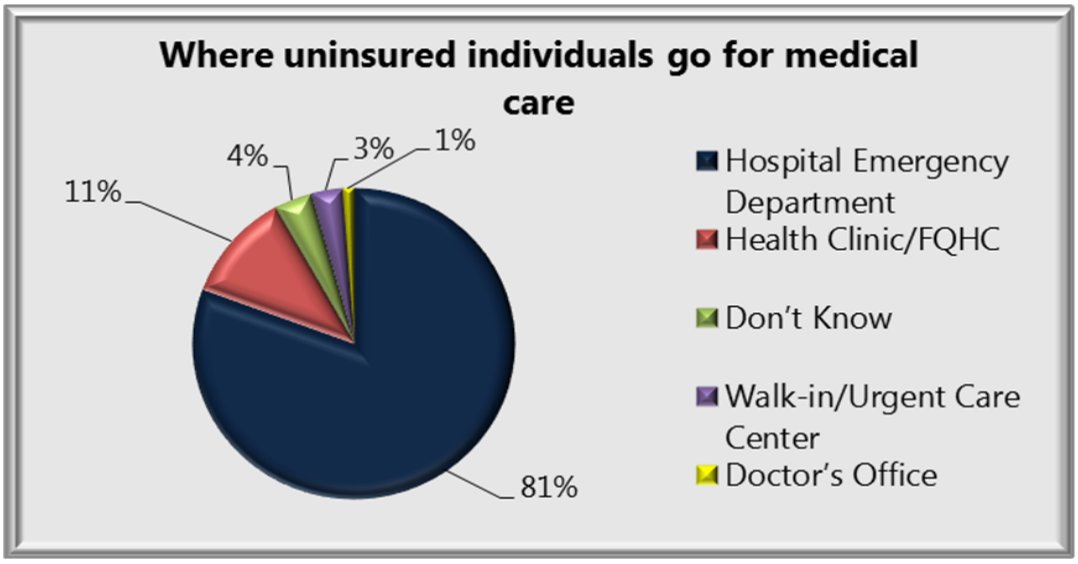


Figure 4: Key informant opinions of where uninsured individuals receive medical care

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that free and low cost medical and dental care, and mental health services are needed. In addition, informants want to see more health education and outreach and more transportation/assisted transportation. Table 5 includes a listing of the resources mentioned ranked in order of the number of mentions.

Table 5: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Free/Low Cost Dental Care	111
2	Mental Health Services	108
3	Free/Low Cost Medical Care	93
4	Health Education/Information/Outreach	78
5	Transportation/Assisted Transportation	69
6	Health Screenings	63
7	Bilingual Services	58
8	Prescription Assistance	58
9	Substance Abuse Services	52
10	Primary Care Providers	39
11	Medical Specialists	32
12	Free/Low Cost Dental Care	111

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Education/Knowledge
- Chronic Conditions/Diseases
- Cultural Norms
- Environment/Safety

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Collaboration/Coordination
- Improved Access to Medical Care, Dental Care, and Mental Health Services
- Improved Access to Affordable Exercise and Nutrition Programs
- Need For Patient Navigation
- Enhanced Programs/Outreach for Youth and Seniors
- Enhanced Community Space

Key Informant Interviews Summary of Findings

Key informants acknowledged that mental/behavioral health, overweight/obesity, and access to care are the most significant health issues in the community. Related to access to care, informants agreed that residents do not have sufficient access to providers and experience a number of barriers in seeking care. In particular, they felt that residents are not able to see specialists, dentists, and mental/behavioral health providers when they need to. They also felt that there are not enough bilingual providers and providers accepting Medicaid and medical assistance. Additional barriers for residents seeking care are out-of-pocket expenses, lack of health insurance coverage, and the inability to navigate the health care system. Informants recommended a number of resources to improve access to care. Among these, free/low cost dental care, mental health services, and free/low cost medical care were cited the most.

Eighty-two percent of informants agreed that there are underserved populations living in Waterbury. Of these populations, they felt that the uninsured/underinsured, low-income/poor, and homeless are the most underserved. When seeking medical care, these populations were thought to most often utilize hospital emergency departments and federally qualified health centers/clinics.

The last portion of the survey asked key informants to identify challenges in the community in maintaining healthy lifestyles and to make recommendations or suggestions for improving health and quality of life. In addition to issues related to access to care, informants listed motivation/effort, education/knowledge, cultural norms, and environment/safety as challenges in the community. To address these issues, informants recommended increasing awareness, education, community outreach, and community collaboration and coordination. They also suggested that more programs for youth and seniors be offered and that the community space be enhanced.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS & PLANNING

Prioritization Session

On June 17, 2013, approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix G.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans. Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

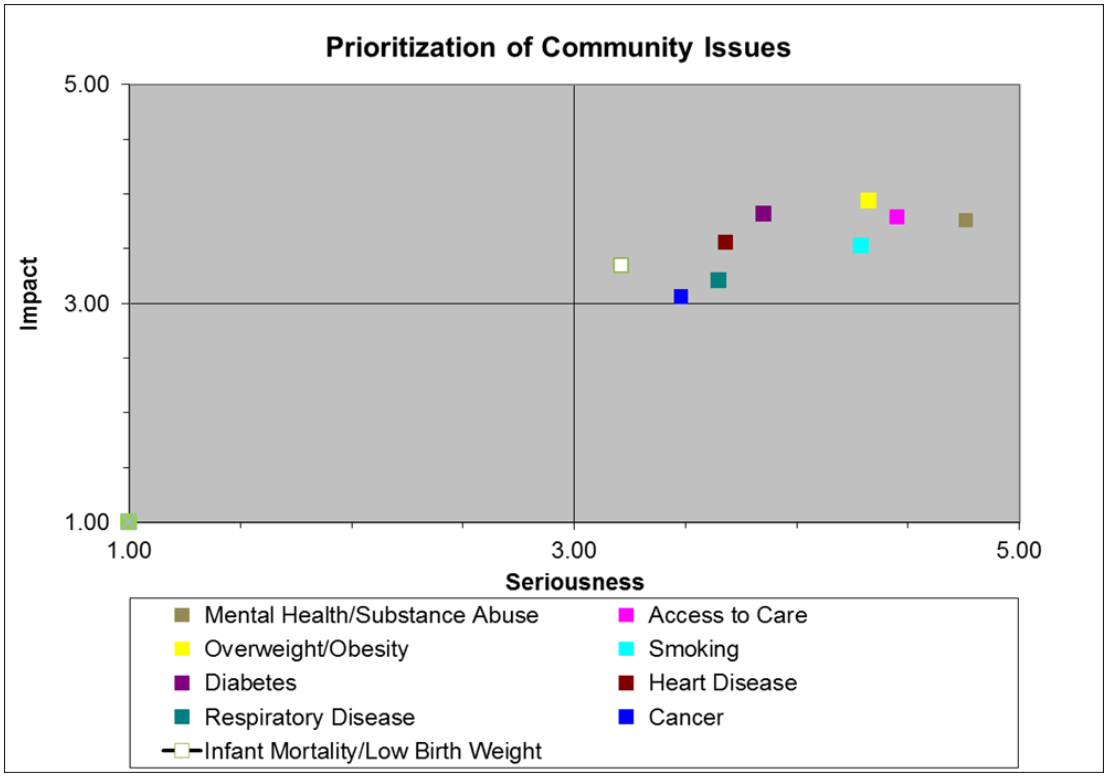
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Goal Setting

Following the prioritization session, The Greater Waterbury Health Improvement Partnership representatives met to review the identified priorities and develop goal statements to guide community-wide health improvement efforts. The following goals were adopted for each priority area:

Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Overweight and Obesity

Goal: Promote health and reduce chronic disease through healthful eating and physical activity.

Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Action Planning

To set a course for ongoing community health improvement activities and evaluation, a Community Health Improvement Plan (CHIP) was developed by the Greater Waterbury Health Partnership. Additionally, in line with requirements set forth in the ACA, specific Implementation Strategies, outlining how each hospital would work to address the identified needs, were created.

The CHIP and Hospital Implementation Strategies were adopted in September 2013. These documents, as well as a report of the CHNA are available on the partner websites.

APPENDIX A: Secondary Data Profile References

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APPENDIX B: Household Telephone Study Statistical Considerations

The Household Telephone Study sampling strategy was designed to represent Waterbury and its surrounding towns. The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (1,121) yields an overall error rate of +/-2.9% at a 95% confidence level. This means that if one were to survey all residents of Waterbury, the final results of that analysis would be within +/-2.9% of what is displayed in the current data set.

Data collected from the 1,121 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for Connecticut and the United States are included when available to indicate how the health status of Waterbury residents compares on a state and national level. All comparisons represent 2011 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to Connecticut and/or national data because of survey modifications.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area. The data was statistically weighted to correct for this over-representation of females. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: Household Telephone Study Participant Demographics

Gender and Age

Demographic Category		Waterbury CT 2013 BRFSS (n = 743)	Surrounding Towns 2013 BRFSS (n = 378)
Gender	Male	36.7%	35.4%
	Female	63.3%	64.6%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 735)**	**Surrounding Towns 2013 BRFSS (n = 374)**
Age Group	18 - 24	2.9%	4.8%
	25 - 34	9.0%	5.3%
	35 - 44	10.2%	12.8%
	45 - 54	17.0%	22.7%
	55 - 64	24.4%	21.7%
	65 years and over	36.6%	32.6%

Race and Ethnicity

Demographic Category		Waterbury CT 2013 BRFSS (n = 737)	Surrounding Towns 2013 BRFSS (n = 378)
Hispanic/Latino	Yes	13.0%	2.6%
	No	87.0%	97.4%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 715)**	**Surrounding Towns 2013 BRFSS (n = 377)**
Race	White	73.6%	94.4%
	Black or African American	16.5%	0.8%
	Asian	1.8%	1.6%
	Native Hawaiian or Other Pacific Islander	0.4%	0.0%
	American Indian or Alaska Native	1.4%	0.5%
	Other	6.3%	2.7%

Marital Status and Children

Demographic Category		Waterbury CT 2013 BRFSS (n = 734)	Surrounding Towns 2013 BRFSS (n = 376)
Marital Status	Married	36.2%	58.0%
	Divorced	16.9%	13.0%
	Widowed	17.8%	13.8%
	Separated	3.0%	0.8%
	Never Married	22.9%	12.5%
	Member of an unmarried household	3.1%	1.9%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 742)**	**Surrounding Towns 2013 BRFSS (n = 378)**
Number of Children in Household	None	74.5%	70.9%
	One	12.3%	14.3%
	Two	8.1%	12.2%
	Three	3.2%	2.4%
	Four	1.1%	0.0%
	Five	0.7%	0.3%
	Six	0.1%	0.0%

Educational Attainment

Demographic Category		Waterbury CT 2013 BRFSS (n = 739)	Surrounding Towns 2013 BRFSS (n = 376)
Education Level	Never attended school or only attended kindergarten	0.4%	0.5%
	Grades 1 through 8	3.7%	2.1%
	Grades 9 through 11	6.5%	2.1%
	Grade 12 or GED	31.9%	20.7%
	College 1 year to 3 years	31.8%	27.1%
	College 4 years or more	25.7%	47.3%

Employment Status

Demographic Category		Waterbury CT 2013 BRFSS (n = 741)	Surrounding Towns 2013 BRFSS (n = 376)
Employment Status	Employed for wages,	38.9%	49.2%
	Self-employed,	3.6%	10.1%
	Out of work for more than 1 year,	4.3%	2.7%
	Out of work for less than 1 year,	2.8%	1.6%
	Homemaker,	3.5%	3.2%
	Student,	1.3%	1.9%
	Retired, or	34.5%	26.9%
	Unable to work	10.9%	4.5%

Income

Demographic Category		Waterbury CT 2013 BRFSS (n = 574)	Surrounding Towns 2013 BRFSS (n = 301)
Income	Under $10,000	8.4%	2.0%
	$10,000 to less than $15,000	13.2%	5.3%
	$15,000 to less than $20,000	6.6%	2.3%
	$20,000 to less than $25,000	10.8%	4.3%
	$25,000 to less than 35,000	14.5%	8.3%
	$35,000 to less than 50,000	14.1%	12.6%
	$50,000 to less than 75,000	14.6%	17.9%
	$75,000 or more	17.8%	47.2%

APPENDIX D: Key Informant Participants

Name	Title	Organization
Tina Agati	Executive Director	Literacy Volunteers of Greater Waterbury
Eric Albert	President	Albert Brothers, Inc.
Michele A. Albini	Constituent Service Aide	City of Waterbury
Janine Altamirano	Program Coordinator	Waterbury Department of Public Health
Maryangela Amendola	Director	Chase Family Resource Center
Joel Becker	President & Chief Executive Officer	Torrco
Carolann Belforti	JobLinks Coordinator	Northwest Regional Workforce Investment Board
Michelle Bettigole	Executive Director	The Watermark at East Hill
Christine Bianchi, MSW, LCSW	Chief Developmental Officer	Staywell Health Care, Inc.
O. Joseph Bizzozero, MD	Administration	Alliance Medical Group
Charles Boulier	President & Chief Executive Officer	Naugatuck Savings Bank
Samuel Bowens	HIV Prevention Coordinator	Waterbury Health Department
Betty Bozzuto	Chief Nursing Officer	Saint Mary's Hospital
Ellen Brotherton	Assistant Director	Western CT Mental Health Network - Waterbury
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Katherine Carten	Parish Administrator	Saint Michael's Parish, Naugatuck
Ellen Carter	Program Officer	Connecticut Community Foundation
Kathy Case	Director of Program Management	Waterbury ARC
Julie Clark	Wellness Environmental Lifestyle Consultant	
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Meghan Cleary	Director of Nursing	Wolcott View Manor
Mary Conklin	Housing Attorney	Connecticut Legal Services
Joseph G. Conrad	Program Director	Connecticut Counseling Centers, Inc.
Ronald Conti	Vice President	Heritage Village
Marilyn Cormack	President	BHCare
JoAnne Cosgriff, MD	Director, Performance Improvement	Waterbury Hospital
Janice Crelan	Assistant Treasurer	Hubbard-Hall, Inc.
Kelly Cronin	Executive Director	Waterbury Youth Services
Andrea Cuff, APRN		Chase Outpatient
Jerome Dais	Elder	Family Worship Center
Kristen Davila	Director	Morris Senior Center
Nancy Deming	Director	VNA Northwest
Catherine R. Dinsmore	Senior Center Director	Falls Avenue Senior Center
Deborah Duarte	Missions President	Community Tabernacle Outreach Center
Richard Dumont	Community Resident	
Kris Durante	Coordinator	Bridge To Success
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Tim Epperson	Food Pantry Coordinator	Greater Waterbury Interfaith Ministries
Michelle Fica	Managing Attorney	Connecticut Legal Services
Bethany Ann Fickes	Office Assistant	Saint Mary's Hospital
Christina Fishbein	Executive Director	Western Connecticut Area Agency on Aging
Ron Flormann	Chief Commercial Officer	Glenwood Systems, LLC
Natalie Forbes	Grant Coordinator	Waterbury Hospital
Auguste Fortin, VI, MD	Physician	Yale Primary Care Residency Program/ Waterbury Hospital
Yvette Highsmith Francis	Regional Director	Community Health Center, Inc.
Todd Gaertner	Nursing Home Administrator	Lutheran Home of Southbury

Sarah Geary	Constituent Services Manager	City of Waterbury
Sharon Gesek	Director of Elderly Services	Town of Southbury
Bill Gibbs	Owner	Bill Gibbs Massage Therapy
Mary-Kate Gill	Director of Elder Services	New Opportunities, Inc.
Jackie Giordano, RN	Nurse	Saint Mary's Hospital
Michelle Godin	Director	Saint Mary's Hospital
Joe Gorman	Supervisor of Health & Physical Education	Waterbury Board of Education
Lydia Granitto	Membership & Marketing Manager	Girl Scouts of Connecticut
Bernadette Graziosa	President	The Grotto Restaurant & Mrs. G's Gift Baskets
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Joy Hall	Director	Salvation Army
Lori Hart	Director	Bridge To Success
Robyn Hawley	Director of Behavioral Health	Catholic Charities Archdiocese of Hartford
Eileen Healy	Executive Director	Independence Northwest, Inc.
Tina Herman	Assistant Director of Critical Care	Waterbury Hospital
Arlene G. Herrick	Property Manager	Grace Meadows Elderly Housing
Chris Hibbs	Health & Wellness Director	Greater Waterbury YMCA
Stephen Holt	Assistant Professor	Yale Primary Care Residency
Geralyn Hoyt	Chief	Southbury Ambulance
Lucia Hughes	Manager	Waterbury Hospital
Stephen Huot, MD	Director	Yale Primary Care Residency Program/ Waterbury Hospital
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Eric Hyson, MD	Attending Physician	Waterbury Hospital
Sandi Iadarola	Chief Nursing Officer	Waterbury Hospital
Azhar Imam, MD	Chief of Psychiatry	Saint Mary's Hospital
Kristen Jacoby, MPH	President/Chief Professional Officer	United Way of Greater Waterbury
Donna Johnson	Community Relations Liaison	Diagnostic Radiology Associates
Mark Johnson, LMFT	Program Director	Wellspring Foundation
Jan Kennedy	Executive Director	Cardiology Associates of Greater Waterbury, LLC
Elizabeth Korn, APRN	Nurse	Saint Mary's Hospital
Lisa Labonte	SNS Director	New Opportunities, Inc.
Leo Lavallee	Principal	Waterbury Arts Magnet School
Stephen Lewis	Chief Executive Officer/President	Thomaston Savings Bank
The Rev. Jeanne Lloyd	Minister	Mattatuck Unitarian Universalist Society
Ben Loveland	Assistant Director	Waterbury Hospital
Vanessa Lucewicz	Practice Manager	Franklin Medical Group
Frederick Luedke	Chairman, Board of Greater Waterbury Health Network Inc.	Waterbury Hospital
Neal Lustig	Director of Health	Pomperaug Health District
Robin Marino	Clinical Manager	Saint Mary's Hospital
Judith Martin	Program Coordinator	Child & Adolescent Behavioral Health
Kate Mattias	Executive Director	National Alliance on Mental Illness Connecticut
Bahar Matusik	Clinical Pharmacy Manager	Waterbury Hospital
Jennifer McGarry	Patient Services Manager	Leukemia and Lymphoma Society
Patricia A. McKinley	Strategic Volunteer to Non-Profit Organizations	Waterbury Health Home Coalition; United Way Greater Waterbury; Connecticut Community Foundation
Kathleen McManamy, LCSW	Regional Supervisor	Connecticut Community Care, Inc.
Kathleen McNamara	Community Resident	
Emmett McSweeney	Library Director	Silas Bronson Library
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Chris Miller	Administrative Fellow	Saint Mary's Hospital

Thomas Missett	Chief Development Officer	Waterbury Hospital
Alan C. Mogridge	Executive Director	Valley YMCA
Peg Molina	Director of Social Services	Town of New Milford
Patrick Morgan	Interim Director Surgical Services	Waterbury Hospital
Drew Morten	Physician Assistant	Connecticut Academy of Physician Assistants
Luci Moschella	Nursing Supervisor	Waterbury Health Department
Lois Mulhern	Nursing Supervisor	Waterbury Health Department
Melanie Nachajska, LCSW		YNA Health Care
James O'Rourke	CEO	Waterbury YMCA
Peggy Panagrossi	Executive Director	Safe Haven of Greater Waterbury
Kim Pernerewski	President	National Alliance on Mental Illness Waterbury
Peter Porrello, MD	Physician	Waterbury Hospital
Pamela Pratt	Manager, OP Behavioral Health	Saint Mary's Hospital
Fenn Quigley	Community Resident	
Ernst Racine, Jr.	Family Center Coordinator/Fatherhood Specialist	Catholic Charities
Loryn Ray, MPH	Director of Elderly Services	Town of Woodbury
Pamela Redmond	Public Affairs Officer	VA Connecticut Healthcare System
Thomas E. Reinahrdt, MD	Chief of Psychiatry	Waterbury Hospital
Laurie Reisman	Director of Operations	Family Services of Greater Waterbury, Inc.
JoAnn Reynolds-Balanda	VP Community Impact	Untied Way of Greater Waterbury
Diane Rokosky, R.N		Public Health Deptartment
P. Russell	Community Resident	
William Rybczyk	Director Research, Development, & Planning	New Opportunities, Inc
Linda Sapio-Longo, APRN	Family Nurse Practitioner	Waterbury Hospital Infectious Disease Clinic
John A. Sarlo	Director	Mattatuck Senior Center, Inc.
Donita Semple	Senior Manager, Performance Improvement	Waterbury Hospital
Loraine Shea	Director	Waterbury Hospital
Frank Sherer	Senior Vice President	Timex Group
Carl Sherter, MD	Chief of Staff	Waterbury Hospital
Catherine Sousa	Supervisor of Patient Transport	Saint Mary's Hospital
Linda Spadaccini	Library Director	Waterbury Hospital
Susan Stauffacher	Chairman	Roxbury Council on Aging
Gary Steck	Chief Executive Officer	Wellmore Behavioral Health
Monica Stokes	Assistant Manager Customer Support	Waterbury Hospital
Christine Thomas-Melly	Benefits Manager	Waterbury Hospital
Donald Thompson	Chief Executive Officer	Staywell Health Center
Joseph M. Tuggle, MD	Physician	Complete Newborn Care, PC
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Kara Vendetti	WIC Program Coordinator	Waterbury Health Department-WIC Program
Deborah Vitarelli	Executive Director	Waterbury Arc, Inc.
Kathy Volz	Practice Manager CFHC	Franklin Medical Group at Saint Mary's Hospital
Chad Wable	President & Chief Executive Officer	Saint Mary's Hospital
Julie Weidemier	Assistant Director	Waterbury Hospital
Claude E. Williams	Executive Director	Mount Olive A.M.E. Zion Senior Citizens Center, Inc.
Jeffrey Williams	Grant Writer	Waterbury Hospital
Eileen Woods	Assistant Director Telemetry	Waterbury Hospital
Kathy Woods	Executive Director	Living in Safe Alternatives, Inc.
D. Woolley	VP Human Resources	Waterbury Hospital
Randy York	Infant Immunization Coordinator	Waterbury Health Department
Mary Zasada	Clinical Informatics Manager	Saint Mary's Hospital
Melissa Zwang	Program Director	New Opportunities, Inc.
Patricia Zuccarelli	Director	Department of Children & Families

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

Waterbury Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Waterbury Hospital was the first hospital in the city of Waterbury and has served the area since 1890. In its first year, Waterbury Hospital served 85 patients and had a staff of 21. It is now licensed for 357 beds and employs more than 2,000 people. The hospital serves approximately 15,000 inpatients, 160,000 outpatients, and 58,000 emergency department visits annually. The mission of Waterbury Hospital is to provide compassionate high quality health care services through a family of professionals and services. The vision of Waterbury Hospital is to be the health care organization of choice by providing superior customer service to patients and physicians.

Waterbury Hospital primarily serves the city of Waterbury and its' surrounding towns. In 2013, Waterbury Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with the Greater Waterbury Health Improvement Partnership. The partnership consists of Waterbury Hospital, Saint Mary's Hospital, Waterbury Department of Public Health, City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Waterbury Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Waterbury Hospital's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs. Waterbury Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA.

THE CHNA PROCESS

A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Identified Community Needs

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Connecticut Department of Public Health, and Centers for Disease Control and Prevention. The information profiles the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Waterbury Hospital in addressing the identified barriers.

Key Informant Interviews were collected via an online survey administered by Holleran. A total of 205 community leaders, including public health experts, health and human services providers, and representatives of underserved populations participated in the survey. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 CHNA and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated and facilitated by the Greater Waterbury Health Improvement Partnership. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives for the day were outlined as follows:

- To review recently compiled community health data and highlight key research findings;
- To initiate discussions around additional key health issues not represented in the CHNA;
- To prioritize the community health needs based on select criteria

Prioritization Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.
Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans.

Master list of community priorities (Presented in alphabetical order.):

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

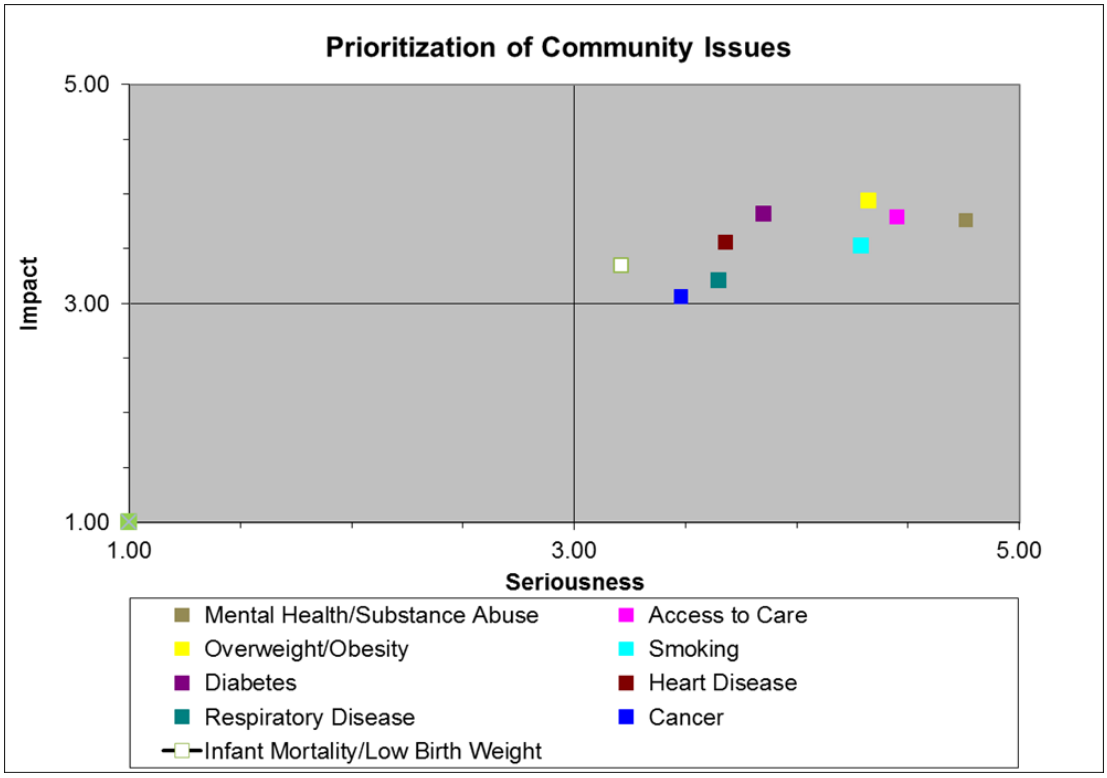
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following five priority areas for Waterbury were adopted:

A. Access to Care
B. Mental Health/Substance Abuse
C. Overweight/Obesity
D. Smoking

WATERBURY HOSPITAL'S STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Waterbury Hospital's Implementation Strategy illustrates the hospital's specific programs and resources that will support ongoing efforts to address the identified community health priorities. This work will be supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, related objectives and strategies, and inventory of existing community assets and resources for each of the four priority areas are listed below.

A. ACCESS TO CARE

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of persons with health insurance
- Increase the proportion of persons who have a specific source of ongoing care
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
- Increase the number of health providers that accept Medicaid and Medicare

Strategies:

1. Increase the number of patients screened and enrolled in insurance programs by WHAP case managers by 10% at the 6 sites in the City of Waterbury by utilizing Certified Assisters to access the CT Health Exchange in response to the Affordable Care Act.

2. Increase the number of patients enrolled in Project Access by 10% for donated, primary and specialty care, reduced prescriptions and Medicare copay assistance, and donated lab and radiology hospital-based services.

3. Provide technical assistance to WHAP sites at St. Mary's Hospital and StayWell Health Center to enable them to track recidivism in the ED for non-emergency codes.

4. Offer 2 onsite bi-lingual medical Spanish classes for 15 clinical staff per class to improve communication with patients.

5. Introduce the CultureVision database to enable healthcare professionals and facilities to provide culturally competent patient care.

Existing Resources:

Underserved Populations
Waterbury Hospital works closely with local healthcare providers and community-based organizations to identify healthcare needs for underserved patients throughout the Waterbury community. Through these collaborations, Waterbury Hospital works to develop key programming for the city's vulnerable populations such as: the Waterbury Hospital Infectious Disease Clinic, which provides comprehensive HIV care to ~500 People Living with HIV/AIDS; and The Waterbury Health Access Program, which provides comprehensive case management services to over 3,000 uninsured and underinsured patients annually; and the Waterbury Hospital Chase Diabetes Disease Management Clinic, is one of the many free clinics offered at Chase Outpatient Center; others include Rheumatology, Surgery, Gastroenterology, Dermatology, Podiatry, and Psychiatry.

During 2012, Waterbury Hospital's spectrum of services continued to have a positive impact on the welfare of Waterbury's citizens. To remain consistent with Waterbury Hospital's mission, many of our services are targeted for vulnerable members of our community, including those who are uninsured or underinsured. In order to provide access to continuing high quality professional health care in the Greater Waterbury area, Waterbury Hospital is a site for 40 clinical programs for new health professionals including: Primary Care Residents, Surgical Residents, Nurses, Physician Assistants, Pharmacy Residents, and Radiology Techs. In addition the Waterbury Hospital Youth Pipeline Initiatives target the emerging workforce in area elementary, middle and high schools.

Health Professions Education

Yale Primary Care Internal Medicine Residency Program
During 2012, our Yale Primary Care Internal Medicine Resident activities included:

- Participation in research days at Yale and Waterbury/St. Mary's Hospitals;
- ACP regional and national meetings;
- The annual Health Fair held at the Waterbury YMCA;
- Home/office visits for clinic patients; and
- Educational seminars held at Waterbury Hospital and Yale University.

At Waterbury Hospital, we seek to train physicians who desire a generalist background to their careers in medicine. This program is unique in that it provides the medical residents the opportunity to work each year in a tertiary medical center at Yale-New Haven Hospital, a community hospital at Waterbury Hospital, and outpatient practice sites that include private practice offices and community health centers is unique in residency training. Our graduates are

highly sought after by private practice offices, hospitalist programs, and fellowship programs throughout the country.

Student Nurse Intern Program (SNI)
The SNI program is available for nursing students entering their senior year. The program provides these student nurses with shadowing opportunities so they can apply their content knowledge to authentic patient care situations. Staff RNs serve as the students' mentors as the students accompany them on their medical rounds. The goals of the program are: (1) to provide the student nurses with the knowledge and skills necessary to pass the NCLEX exam and (2) to socialize the student nurse in an attempt to decrease the stress of assimilating into the hospital's work environment, should they be hired as Graduate Nurses at Waterbury Hospital.

Physician's Assistant (PA) Students
P.A. students from Quinnipiac University completed clinical rounds in several departments around the hospital, including the Operating Room, Emergency Department, Behavioral Health, and Radiology. The experience is designed for the student to learn to apply the knowledge gained from didactic course work in medicine, surgery, and the basic and behavioral sciences into the clinical arena resulting in the ability to successfully manage patients in a thorough and comprehensive manner. The primary goal of clinical rotations is to expose the student to patients of all ages, patients in a variety of different settings, and patients with a broad range of medical, surgical, and psychosocial problems.

The P.A. students participate in:

- History taking;
- Examining the patient;
- Assisting in and/or performing diagnostic testing;
- Assisting in and/or performing therapeutic tasks;
- Oral presentations;
- Medical documentation of the patient encounter;
- Formulating a differential diagnosis and problem list;
- Formulating a treatment plan; and
- Counseling of patients regarding medication, diet, and lifestyle changes such as smoking cessation, exercise, and well-being.

Radiology Students from NVCC
The Naugatuck Valley Community College (NVCC) Radiology students are involved with many activities while assigned to Waterbury Hospital. Under the supervision of a NVCC clinical instructor and hospital radiologic technologists, the students are assigned to the various radiographic suites and modalities. During their assignment, students are performing or assisting with radiographic procedures, including chest x-rays, skeletal exams, fluoroscopic procedures, mobile x-rays in the various patient units, and surgical cases. The students also increase the number of individuals available in the department to assist in moving and transporting patients as well as chaperoning sensitive exams. In addition to the diagnostic

radiology the students are assigned to experiences in Interventional Radiology, CT, MRI, Nuclear Medicine, and Ultrasound. Students work in these modalities under the direct supervision of the hospital staff.

Waterbury Hospital's affiliation with NVCC as a clinical site for students has many benefits. Perhaps the single most important benefit is the hospital has a continuous stream of potential radiology employees. Students are in the program for 22 months and in that time become very familiar with the hospital equipment, routines, personal, and mission. This provides Waterbury Hospital with new employees who have a strong skill set and proven dedication to the hospital community.

Waterbury Hospital Youth Pipeline Initiatives

The Waterbury Hospital Youth Pipeline Initiatives were established in 2001 as a partnership between Waterbury Hospital and Waterbury Public Schools. The mission of the program is: "to close the achievement gap for minority and economically disadvantaged students in Waterbury so they can matriculate and compete nationally for placement in post-secondary education programs in preparation for health careers". Waterbury Hospital is committed to enhancing and enriching the academic opportunities and personal journeys of our youth, who are the emerging workforce of tomorrow. To this end, during 2012, Waterbury Hospital continued to provide 383 students and parents in Greater Waterbury with unique educational programs that will enhance the overall welfare of our community. The WH Youth Pipeline Initiatives had four focus areas during FY 2012, including:

Providing Early Acquaintance with Careers in Healthcare (PEACH)

Since its inception in 2004, Waterbury Hospital's Providing Early Acquaintance with Careers in Healthcare (PEACH) Program has engaged administrators, teachers, and students at Waterbury's North End Middle School and West Side Middle School to address projected shortages of healthcare workers and to close the achievement gap for students in Waterbury Public Schools. Through the PEACH Program, students engage with healthcare workers in a non-emergency setting and are informed of the variety of healthcare career opportunities available in our community. Each spring, approximately 100 seventh graders from Waterbury take part in a day-long PEACH tour at Waterbury Hospital, during which they visit at least six hospital departments and complete hands-on learning activities with hospital staff. Annually, Waterbury Hospital also offers its PEACH Spring Break Exploration Camp, this year 38 middle school students from Waterbury took part in: shadowing and hands-on learning activities at the hospital; CPR certification; and educational sessions at Bridgeport's Discovery Museum.

Parent Leadership Training Institute (PLTI)

In 2012, twenty four individuals from Greater Waterbury successfully completed Waterbury's PLTI, a 20-week curriculum teaching leadership and advocacy skills. Waterbury Hospital has hosted the Waterbury PLTI since 2000, and the program has trained and graduated over 175 area parents. PLTI's core mission is to impart leadership and advocacy skills to parents while simultaneously educating them about volunteerism, civic life, and the process by which state

and local governments enact and change laws. Each participant completes and implements a community project; examples of projects from 2012 include: a "High School Driving Education" program (a City-wide initiative to introduce safe driving techniques in high schools) and "The C.H.I.P. Forum" (Children Having Involved Parents—a series of workshops to underline the importance of giving encouragement and support to our children so they can succeed in life).

Parents Supporting Educational Excellence (PSEE)

In 2012, twenty-one individuals from Greater Waterbury successfully completed Waterbury's PSEE, a 13-week curriculum co-created by the Connecticut Center for School Change and the Connecticut Commission on Children for parents (defined broadly as parents, guardians, family members and grandparents) to instill leadership skills in education and to facilitate partnerships between school staff and parents to improve student learning.

WH Summer Bridge Program

During the summer of 2012, twenty-eight students from Waterbury, grades 6-11, participated in the WH Summer Bridge Program. 100% of meals were secured for the program from City of Waterbury Summer Food Program and 8 local restaurants/businesses. Students completed the following modules:

- 78.5 hours of Academic preparation
- 15 hours of job shadowing sessions (Radiology, Nuclear Medicine, Nursing, MRI, Case Management, Dr. S. Aronin (ID Inpatient Rounding), ICU Medical Rounds, Health Information Management, Access Rehab, Behavioral Health, Respiratory Therapy, Finance, WH ID Clinic, Security, Orthopedics, Pharmacy, Infection Control and Surgery.
- 14 hours of Photography instruction
- 4 hours of computer sessions
- 2 full-day field trips completed: one to Yale University for an admissions info session and campus tour and one to Hammonasset State Park including three educational sessions at Meigs Point Nature Center
- 3 hours of healthcare career searches
- 3 hours of college admissions presentations completed by UCONN Waterbury & Yale ROTC
- 1 hour of individual academic advising
- 2 hours of team building activities
- 2 hours of health topics presentations completed, including HIV 101 and Healthcare Jeopardy.

Waterbury Health Access Program

Waterbury Hospital is aware of the economic needs many patients in our community, and, as a result, we remain committed to the Waterbury Health Access Program. Founded in 2003 as a partnership between Waterbury Hospital, St. Mary's Hospital, StayWell Health Center (FQHC), and the Waterbury Health Department, the Waterbury Health Access Program improves access to high-quality medical care by providing comprehensive case management, pharmacy

assistance, and access to primary and sub-specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. During FY 2012, the Waterbury Health Access Program had over 4,700 active clients. Additionally, Waterbury Hospital provided $784,879 worth of donated services to WHAP's patients.

Waterbury Hospital Infectious Disease Clinic (WHIC)
The WHIC offers a comprehensive "one-stop shopping" model that provides patients with on-site primary and specialty services, medical case management, individualized medication adherence services, mental health and substance abuse services, nutrition counseling, individualized HIV education, laboratory testing, and radiology services. WHIC's providers include three board-certified/board-eligible Infectious Disease specialists as well as an Advanced Practitioner Nurse and a Registered Dietician, all with expertise in the management of patients with HIV/AIDS. In FY 2012, WHIC served around 500 People Living with HIV/AIDS (PLWHA).

WHIC's staff members actively participate in statewide and area collaboratives, such as the Connecticut HIV Planning Consortium (CHPC) and the Ryan White Part A Planning Council, and WHIC facilitates the Greater Waterbury HIV Consortium. WHIC has a very active Consumer Advisory Group (CAG), which organizes social and testing events for the community and facilitates the Waterbury Hospital Photography Group.

The WHIC also has a Hepatitis C clinic, run by an Advanced Practitioner Nurse. From October 2004 to Present, nearly 200 Hepatitis C mono- and co-infected (Hepatitis C and HIV) patients have been evaluated at the ID Clinic. The Hepatitis C clinic provides a consultation with a nutritionist to advise on healthy eating; coordination with mental health services; and educational sessions on side effect management, the importance of hydration and adherence, and positive coping strategies.

Be Well Bus
In order to ensure that patients have access to medical appointments, at the hospital and at local physicians' offices, Waterbury Hospital's Be Well Bus provides transportation services to patients from Waterbury and eleven of its surrounding towns. During FY 2012, the Be Well Bus completed over 4,170 transports to and from medical appointments. Waterbury Hospital has contracted with a transportation provide to offer the bus service, and area providers pay a small fee to participate.

Diabetes Disease Management (DDM) Clinic
The DDM utilizes a multidisciplinary case management approach to develop treatment plans and monitor patient progress. The DDM Clinic provides >150 diabetics with self-management skills and clinical care. The clinical team meets weekly on Wednesdays to develop treatment plans for new patients and collaborate on the progress of existing patients.

Evergreen 50 Club
Waterbury Hospital's Evergreen 50 Club is an organization comprised of over 15,000 members over the age of 50. The Club offers wellness programming, Medicare counseling, and health education presentations on a variety of topics are presented by health care professionals. Presentation topics include: holistic health, varicose vein treatment, heart disease, summer skin care, weight loss, blood pressure, bladder screenings, joint care and replacement, nutrition, and resolving adverse outcomes with patients and families. Annually, the Evergreen 50 Club hosts a health fair for its members, which provides free flu shots and healthcare screenings.

Family Birthing Center
Providing a child-centered focus, Waterbury Hospital's Family Birthing Center offers expectant parents a variety of classes to prepare them for their baby's arrival. Between breast feeding, childbirth, infant care classes, and nutritional presentations at our Family Birthing Center provided vital instruction to over 120 persons last year.

Heart Center of Greater Waterbury
Formed in collaboration with Saint Mary's Hospital, the Heart Center of Greater Waterbury provides diverse medical support initiatives to help educate residents in the Greater Waterbury community about pertinent health and wellness issues. This past year, the Heart Center conducted a series of health fairs and various health and wellness education sessions, including "Ask the Nurse," which provides patients with complimentary blood pressure screenings and health awareness education and a "Freedom from Smoking" series to help our residents kick the habit. During FY 2012, the Heart Center's programs served over 3,280 residents from the Greater Waterbury Area.

Thank God I'm Female
For the past 20 years, Waterbury Hospital's "Thank God I'm Female" has served as an annual women's wellness forum that features 40 educational booths and health-related giveaways. The ultimate goal of the forum is to educate attendees about stress, mental well-being, heart health, diet, healthy cooking, osteoporosis and bone health, change of life, and more. In 2012, over 400 area residents attended the event.

Waterbury Research Day
Through collaboration with St. Mary's Hospital in Waterbury, CT, Waterbury Hospital hosted its annual Waterbury Research Day. During the day, resident physicians, pharmacy residents, and medical students present research projects to the physician community. High school students are also encouraged to participate in the activities.

B. MENTAL HEALTH AND SUBSTANCE ABUSE

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase cultural competency among mental health and substance abuse providers
- Increase number of points of access for referral to services
- Reduce stigma of mental health and substance abuse disorders
- Increase community support structures and individual resiliency skills
- Increase the proportion of adolescents never using substances
- Reduce illegal substance use

Strategies:

1. Establish bi-annual education/family support seminars which would be available to clients, families and community members.

2. Expand student/intern program to provide clinical training rotations throughout the Department of Behavioral Health. Up to 5 academic year internships would be offered annually to master's level students pursuing education in addictions and mental health.

3. Initiate specialized programming on the inpatient adolescent unit to incorporate Dialectical Behavior Therapy (DBT) skills as well as goal setting to decrease the rates of seclusion and restraint.

4. Maximize resources within the Access Center to increase number of individuals served by 10% by providing assistance and "bridge" treatment to ensure continuity of care between services, and urgent/emergent assistance where needed to prevent decompensation and unnecessary hospitalization.

Existing Resources:

Behavioral Health

Waterbury Hospital's Behavioral Health Department is one of the region's largest service providers offering a full continuum of care for children, adolescents and adults. Our services also outreach to the community through regular participation in health fairs, elected membership in the Northwest Regional Mental Health Board, as a host site to numerous twelve-step meetings and the provision of case management as well as acute services to the homeless within the City of Waterbury.

Grandview Adult Behavioral Health
Grandview Adult Behavioral Health is the adult component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals ages eighteen and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; gender specific programming, cognitive therapy and DBT (Dialectical Behavior Therapy). Services provided in the Intensive Outpatient and traditional Outpatient Programs include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy

West Main Behavioral Health
West Main Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age eighteen and up who suffer from a variety of substance use disorders as well as concurrent psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; motivational interviewing, cognitive therapies and suboxone induction/maintenance.

Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, ambulatory detoxification, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, family therapy and multifamily therapy are also provided when clinically indicated. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Center for Geropsychiatry
The Center for Geropsychiatry is one of the adult components of the Behavioral Health Department ambulatory care service. Comprehensive psychiatric treatment is offered to individuals age sixty and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.

Services provided in the Outpatient Program include comprehensive psycho diagnostic assessment and evaluation, family therapy, group therapy, milieu therapy, and pharmacotherapy. Individual and Family Therapy is provided as needed.

Child and Adolescent Behavioral Health
Child and Adolescent Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age ten to eighteen who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders.

Limited outpatient services are provided to individuals aged 12-21 who are transitioning to outpatient and/or adult services. Intensive ambulatory services are organized to promote recovery from psychiatric disorders through active treatment outside of an inpatient setting. Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are also provided when clinically indicated. Transportation services are available to patients for partial hospital visits as needed. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Services provided in the Intensive Outpatient Program and Outpatient Service include comprehensive psycho diagnostic assessment and evaluation; group therapy; milieu therapy; and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are provided when clinically indicated.

Crisis Center/ Access Center

The Crisis Center provides urgent/emergent evaluations and short term treatment to all individuals presenting to the Emergency Department and/or Crisis offices with immediate and acute behavioral health needs. Consultation services are provides on the inpatient medical floors when ordered by an attending physician. Evaluative services are provided for any individual regardless of their age.

Services are provided to individuals who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, substance use disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.
Active collaboration and coordination of care occur with the patients, the crisis clinicians and community provides to ensure a smooth transition from crisis services to the next appropriate treatment setting.

Program hours are Seven days per week between 8 am and midnight. Services are open and available 365 days per year.

Center for Behavioral Health

Behavioral Health Services provided include psychiatric evaluations, OT/AT evaluations, family therapy, group therapy, didactic educational groups, individual counseling and recreational services all within a milieu framework offering twenty four hours services within an inpatient hospital setting. Inpatient services are available within separate subunits to adolescents (ages 12- 18) as well as adults age 18 and over. Diagnostic services are available when indicated within the general hospital and include clinical laboratory, radiology and medical/service allowing for comprehensive consultations.

Our efforts are aimed at promoting the benefits of clinical treatment as well as positive lifestyle choices. Every effort is made to educate clients, their families and the community about mental

illness and the impact treatment can have on one's illness. The ultimate goal is to help people feel better, reduce or resolve symptoms and to minimize the stigma of mental illness.

Support Groups
During 2012, Waterbury Hospital hosted several support groups for its patients and their families, including:

- Behavioral Health's parent and sibling support group, which offers emotional assistance to families who have children in treatment; and
- Alcoholics Anonymous, serves over 4,000 people annually, meets weekly throughout the year, and is coordinated by our Behavioral Health Department.

C. OVERWEIGHT AND OBESITY

Goal: Promote health and reduce chronic disease through healthy(ful) eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Increase access to and use of safe areas for physical activity
- Increase residents knowledge/awareness of a balanced diet and physical activity
- Reduce risk factors for chronic disease

Strategies:

1. The WH Wellness Committee initiates events and activities focused at supporting the physical and mental wellbeing of the WH staff and residents in the county. Initiatives include: (1) Establish a weekly Farmer's Market in conjunction with Waterbury's Brass City Harvest on Hospital grounds to increase access to and encourage consumption of healthful foods. (2) Establish a "Get Moving" program to encourage physical fitness for employees, patients, and community members.

2. Increase nutritional education within the child and adolescent Behavioral Health program as well as the implementation of a "low ropes" program to increase self-awareness, skill building, and physical fitness.

3. Increase the number of patients receiving nutritional counseling and self-management education at WH ID Clinic, and WH DDM Clinic by 10%. Referrals to the WH outpatient dietitian are made when clinically indicated.
4. Publish calorie counts for all foods in the WH Cafeteria by December 2014.

5. Conduct an employee health risk assessment in January 2015 to 100% of WH employees with health insurance through WH to encourage positive health engagement with a discount deductible incentive.

6. Expand the physical fitness program in collaboration with the Waterbury YMCA at the DDM Clinic to include 20 patients of the WH ID Clinic.

Existing Resources:

Nutritional Counseling
Patients admitted to WH (inpatient) are screened within 24 hours to assess for nutrition risk; those patients that are at high nutrition risk trigger a consult to the Registered Dietitian. MDs and other providers can order an RD consult for any patient they feel should be seen by an RD (including diet education). In addition, all patients of WH DDM Clinic and WH ID Clinic are seen by a Registered Dietitian and are provided with appropriate nutritional counseling and self-management training. Patients at both clinics are seen as often as necessary to teach nutrition concepts and help them to make desired lifestyle changes; these patients are seen at least annually.

Supporting Community Need
The WH ID Clinic runs a Food Pantry for HIV patients. WH also routinely responds to requests from the community through organized campaigns for specific items run by its employees ie the annual Thanksgiving Turkey drive in November and the annual Cereal drive in May, to help families prepare to feed children breakfast during the summer months when school is out.

Patient Fitness
The DDM Clinic has established an established an arrangement with the Greater Waterbury YMCA to provide monthly memberships to DDM patients to promote a regular exercise regime; 21 patients were referred from January through November 2012.

Employee Fitness
WH maintains an onsite Fitness Center for employee use, open 24 hours a day, seven days a week. Employees pay a one-time, $10 life-time membership fee. WH employees also receive a discount on Waterbury YMCA memberships. Additionally, WH supports on-line participation in Weight Watchers programs for its employees.

Community Fitness
The Evergreen 50 Club offers multiple 'keep fit' programs for community members and staff over 50 years old. Classes include Pilates and weight training.

D. TOBACCO USE

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Strategies:

1. Provide tobacco screening to 100% of patients and education to 100% of patients who smoke before their discharge from WH.
2. Increase tobacco screening and education to 100% of outpatients seen in the primary care medical practice for continuity visits at the Chase Outpatient Center. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
3. Screen 100% of patients in the WH ID Clinic for tobacco use. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
4. Participate in the American Lung Foundation's annual 'Great American Smoke Out' program through the WH Wellness Committee.

Existing Resources:

WH successfully transitioned to a Tobacco free campus in November 2010.

Tobacco screening is provided to 100% of patients in the WH Behavioral Health Department and education is provided to 100% of patients who tobacco users. Resource information on smoking cessation is provided in all patient waiting areas.

WH is collaborating with the Regional Mental Health Board and will be providing smoking cessation groups along with one to one telephonic coaching.

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Waterbury Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Waterbury Hospital Board of Directors met on September 26, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the **2013 Waterbury CHNA Final Report**, the **2013 CHNA WH Implementation Plan**, and the **2013 CHNA WH Implementation Plan Summary**, and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT 7

Saint Francis *Care* ~ Service Lines and Support Platforms

Service Lines

- Behavioral Health
- Cardiovascular
- Connecticut Joint Replacement Institute
- Emergency Medicine & Pre-Hospital
- Medicine
- Oncology
- Physical Medicine & Rehabilitation
- Primary Care
- Surgery
- Women & Children

Support Platforms

Clinical
Care Coord / Case Mgt
Critical Care
Diagnostics
Infection Control
Informatics
Nursing Practice
Pastoral Care
Patient Liaisons
Pharmacy
Quality / Risk Mgt

Business & Services
Business Development
Compliance
Enterprise Risk Mgt
Finance / Audit
Government Relations
Human Resources
Information Technology
Legal / Regulatory
Marketing / Comm
Mission Integration
Strategic Planning
Supply / Materials Mgt

Innovation & Learning
Education
Innovation
Leadership Development
Library
Performance Improvement
Research
SFC Solution System
Simulation

Facilities
Biomedical
Engineering
Food Services
Housekeeping
Laundry
Security
Space Management
Transport

focus on Patient Experience runs through all

EXHIBIT 8

SFC Alliance Approach

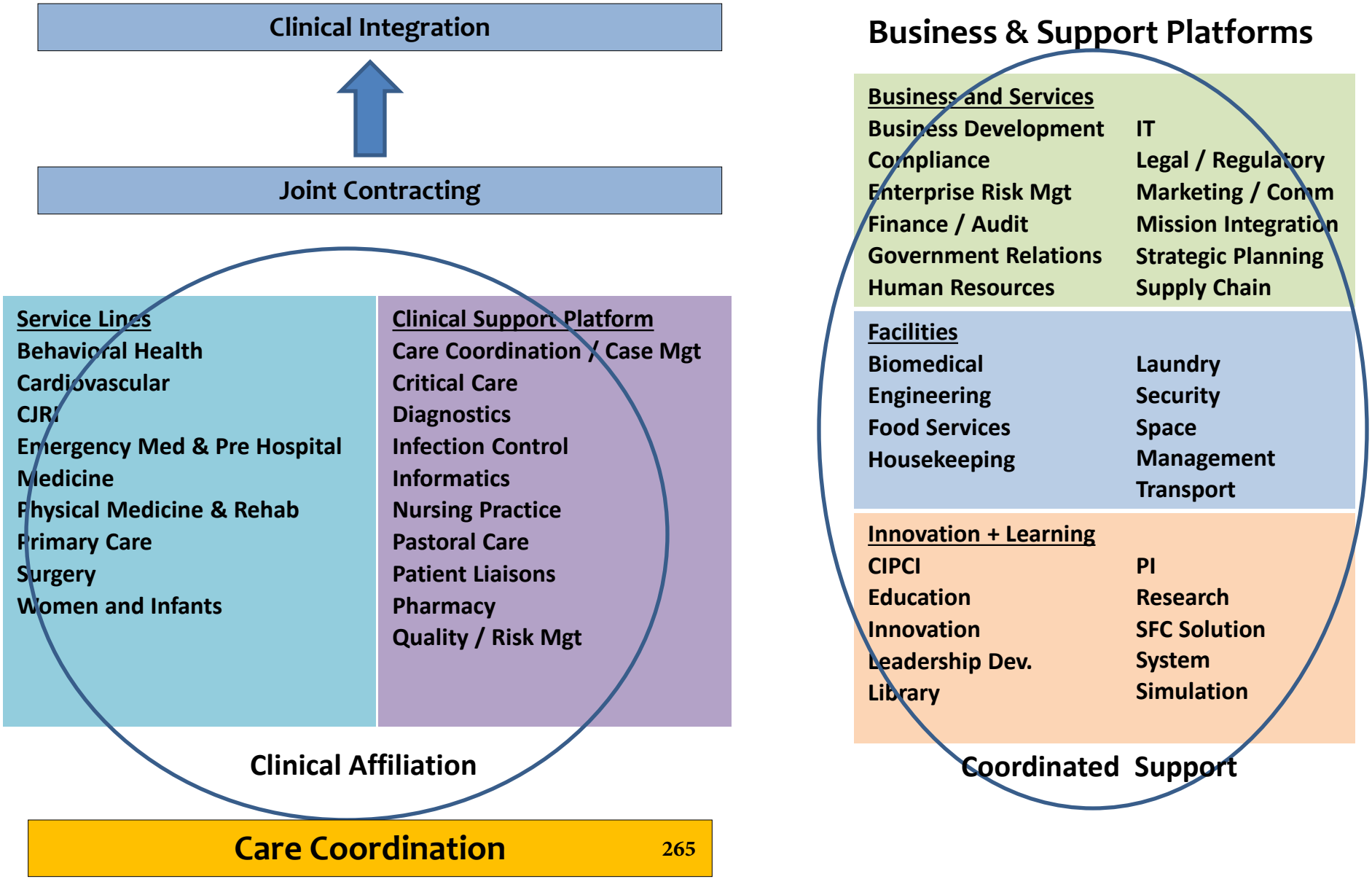


EXHIBIT 9

Saint Francis *Care* Awards and Recognitions

NCDR ACTION Registry – GWTG Platinum Award – Saint Francis has received the American College of Cardiology's NCDR ACTION Registry–GWTG Platinum Performance Achievement Award for 2015. Saint Francis *Care* is one of only 319 hospitals nationwide to receive the honor. The award recognizes Saint Francis's commitment and success in implementing a higher standard of care for heart attack patients and signifies that Saint Francis has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations. (July 2015)

Most Wired – 2015 – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2015 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the sixth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2015)

US News & World Report/Best Hospitals for Common Care – Saint Francis was recognized as "High Performing" for the treatment of COPD and Knee Replacement. (June 2015)

Premier Inc., Diversity Award – Saint Francis *Care* received the *Diversity Award* at Premier's annual Breakthroughs Conference and Exhibition. The *Diversity Award* honors health systems that have established active programs to evaluate and support minority-, women- and veteran-owned enterprises, as well as small businesses, available through the Premier contract portfolio. (June 2015)

American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award – Saint Francis Hospital and Medical Center has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation's secondary prevention guidelines for patients with heart failure. This marks the sixth year that Saint Francis has been recognized with this award. Saint Francis also received the association's *Target: Heart Failure Honor Roll.* This initiative provides hospitals with educational tools, prevention programs and treatment guidelines designed to reduce the risk of heart failure patients ending up back in the hospital. Saint Francis is the only hospital in the state to earn the *Target: Heart Failure Honor Roll* distinction. (June 2015)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2015)

Associated Builders and Contractors Excellence - Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 2015)

Becker's Hospital Review – Becker's Hospital Review a leading source of information for healthcare professionals, has listed Saint Francis Hospital and Medical Center among the top 100 hospitals in the country with "great women's health programs." Hospitals were selected for the list based on clinical accolades and recognition for women's health excellence from various healthcare groups and agencies. Those agencies include U.S. News & World Report, Healthgrades, CareChex and UNICEF's Baby-Friendly Hospital Initiative. Saint Francis was one of three hospitals in Connecticut named to the list, along with Hartford Hospital and Yale-New Haven Hospital. (December 2014)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 30, 2015)

Associated Builders and Contractors Excellence - Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 29, 2015)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2015 *Best Hospitals for Patient Safety*. The award is based on consistently low rates of infections and surgical errors, and patient recommendations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (December 3, 2014)

The LeapFrog Group "A" Score –Saint Francis *Care* has again received an "A" rating Hospital Safety Score℠ from the Leapfrog Group, a national hospital quality watchdog organization. The Leapfrog Group has released its fall 2014 Hospital Safety Scores. For the 6th consecutive time Saint Francis has received an "A" rating. Saint Francis is one of only four hospitals in the state to earn the highest rating and the only Connecticut hospital to receive the "A" rating in both the fall and the spring. Six hospitals received "B" ratings; 12 a "C" rating; and three a "D" rating in the recent rankings. Overall, Connecticut ranked 33rd out of 42 states, with just 16% of its 25 rated hospitals receiving an "A" grade. The Hospital Safety Score℠ for 2014 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. The grades are derived from analysis of publicly available data using 28 evidence-based, national measures of hospital safety. (November 2014)

CareChex – Saint Francis Hospital and Medical Center has also been recognized by CareChex®, a division of Comparion Medical Analytics, for national and state medical excellence achievements in numerous categories in its 2015 hospital quality award rankings. Saint Francis was ranked

90th nationwide for overall medical excellence in hospital care among nearly 4,200 hospitals reviewed, and was the only Connecticut hospital to score in the top 100.

The Hospital also ranked nationally among the hospitals reviewed as:

- #5 in coronary bypass surgery (out of 1,196 hospitals scored)
- #8 in joint replacement (out of 3,497 hospitals scored)
- #9 in major orthopedic surgery (out of 3,499 hospitals scored)

In addition, Saint Francis ranked #1 in Connecticut in the following eight clinical and surgical areas:

- Overall Hospital Care – Medical Excellence
- Overall Surgical Care – Medical Excellence
- General Surgery – Medical Excellence
- Joint Replacement – Medical Excellence
- Neurological Surgery – Medical Excellence
- Orthopedic Care – Medical Excellence
- Orthopedic Surgery (Major) – Medical Excellence
- Spinal Surgery – Medical Excellence

(November 2014/For internal non-commercial use only.)

Healthgrades® – Saint Francis *Care* has been recognized for clinical excellence in a national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *2015 Quality Achievements Report:*

- *Saint Francis Care earned the Distinguished Hospital Award for Clinical Excellence in 2015. (Embargo January 20, 2015)*
- *100 Best Hospitals for Coronary Intervention, 2 years in a row*
- *Coronary Intervention Excellence Award, 2 years in a row*
- *Top 10% in the Nation for Coronary Interventional Procedures*
- *Recipient of the Healthgrades Stroke Care Excellence Award*
- *Top 10% in the Nation for Treatment of Stroke*
- *100 Best Hospitals for Joint Replacement, 3 years in a row*
- *100 Best Hospitals for Orthopedic Surgery, 2 years in a row*
- *Joint Replacement Excellence Award, 3 years in a row*
- *Orthopedic Surgery Excellence Award, 2 years in a row*
- *Top 5% in the Nation for Joint Replacement, 3 years in a row*
- *Top 5% in the Nation for Overall Orthopedic Service, 2 years in a row*

Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: coronary intervention procedures, treatment of heart attack, coronary bypass surgery, treatment of stroke, repair of abdominal aorta, total knee replacement, total hip replacement, and for spinal fusion surgery. (DHACE, January 20, 2015; Specialty Excellence Awards, October 21, 2014)

Becker's Hospital Review – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "125 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is one of only two Connecticut hospitals on the list. This is the fifth year Becker's Hospital Review has compiled this list, and the first time it has included 125 hospitals. (September 2014)

Joint Commission's Gold Seal of Approval/Stroke Center Accreditation – Saint Francis Hospital and Medical Center has earned *The Joint Commission's Gold Seal of Approval®* for accreditation of its Stroke Center by demonstrating compliance with The Joint Commission's national standards for healthcare quality and safety. The accreditation award recognizes Saint Francis's dedication to continuous compliance with state-of-the-art standards in its primary care stroke center operations. (August 2014)

U.S. News & World Report – In a national survey of 4,806 hospitals, Saint Francis Hospital and Medical Center was one of 752 hospitals to achieve at least one "High Performing" rating among 16 medical specialties in the 25th annual U*.S. News & World Report* ranking Best Hospitals in the U.S. Saint Francis was recognized as high performing in 9 specialties: Cardiology and Heart Surgery; Ear, Nose and Throat; Gastroenterology and GI Surgery; Geriatrics; Nephrology; Neurology and Neurosurgery; Orthopedics; Pulmonology; and Urology. (July 2014)

LifeChoice Donor Services – Saint Francis Hospital and Medical Center earned a gold award for their work with LifeChoice Donor Services. LifeChoice Donor Services is among a select group of organ procurement organizations (OPOs) nationwide recognized by the U.S. Department of Health and Human Services (HHS) for reaching gold, silver, and bronze levels of achievement for conducting activities that promote enrollment in state organ, tissue and eye donor registries. The hospitals are part of a national hospital campaign, sponsored by HHS's Health Resources and Services Administration (HRSA), which has added 327,659 donor enrollments to state registries nationwide since 2011, exceeding the goal of 300,000. (July 2014)

American Diabetes Association – The American Diabetes Association Education Recognition Certificate for a quality diabetes self-management education program was recently awarded to the Center for Diabetes and Metabolic Services at Saint Francis. The designation assures that programs meet the national standards for Diabetes Self-Management Education Programs. (July 2014)

Most Wired – 2014 – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2014 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the fifth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2014)

Healthgrades: Patient Safety & Women's Health Excellence Awards – **Saint Francis Hospital and Medical Center** received the *2014 Patient Safety Excellence Award™* and the *Women's Health Excellence Award*, from Healthgrades, the leading online resource for comprehensive information about physicians and hospitals. (June 2014)

- *The Patient Safety Excellence Award* distinction places Saint Francis within the top 10% of all hospitals for its excellent performance in safeguarding patients from serious,

potentially preventable complications during their hospital stays. This is the fourth consecutive year that Saint Francis has received this award, and one of only two Connecticut hospitals to earn the distinction this year.

- The *Women's Health Excellence Award* distinguishes Saint Francis as a top-performing hospital in women's health. Saint Francis is one of only 178 recognized nationally for their outcomes for care provided to women for common conditions and procedures treated in the hospital. Saint Francis is on the only hospital in Connecticut to earn this distinction.

Premier Supply Chain Excellence Award – Saint Francis Hospital and Medical Center has received *Premier, Inc.'s Supply Chain Excellence Award* for superior supply expense performance. Saint Francis is one of only 35 Premier members to receive the award this year. Premier, a leading healthcare improvement company, unites an alliance of approximately 3,000 U.S. hospitals and 110,000 other providers. (Embargo Date: June 11, 2014)

American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award – Saint Francis has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation secondary prevention guidelines for heart failure patients. This marks the third time that Saint Francis has been recognized with a quality achievement award. (May 2014)

The LeapFrog Group "A" Score – Saint Francis Hospital and Medical Center has again received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. This is the 5th consecutive "A" rating received by Saint Francis from The Leapfrog Group. Saint Francis was one of two hospitals in the state to receive an "A" grade from Leapfrog in the latest rating for spring 2014, and the only hospital to receive the "A" rating in both the fall and spring. Among the 25 Connecticut hospitals, 8 received a "B," 13 received a "C," one received a "D," and one received an "F." Scores went down for four hospitals, while three hospitals improved their scores. (April 2014)

Women's Choice Award – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2014 Best Hospitals for Patient Experience in Heart Care. The award is based on robust criteria that include female patient satisfaction measurements as well as clinical excellence considerations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2014)

Becker's Hospital Review – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "100 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is the only Connecticut hospital on the list. (January 2014)

Becker's Hospital Review– Saint Francis Hospital and Medical Center was named on the Becker's Hospital Review list of *100 Hospitals with Great Heart Program*. Becker's rates hospitals based on recognition for quality care, clinical awards and research contributions to cardiovascular care. (December 2013)

Alliance of Independent Academic Medical Centers (AIAMC) – Saint Francis *Care* received the *2014 Innovation Award* from the Alliance of Independent Academic Medical Centers (AIAMC) in recognition of the innovative medical education programs for residents, physicians and staff that have resulted in better patient outcomes. This is the second time the Hospital received the Innovation Award. (December 2013)

Association of American Medical Colleges – The Innovation + Learning Center at Saint Francis was one of national 13 recipients to receive the *Association of American Medical Colleges Learning Health System Challenge and Planning Award*, which recognizes innovations in medical education, care delivery, research, and diversity and inclusion. At Saint Francis, the award was given for emphasis on studying efforts to improve everyday clinical practice and health equity in an accountable care environment across the system. (December 2013)

Healthgrades® – Saint Francis *Care* was recognized for clinical excellence in a new national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *American Hospital Quality Outcomes 2014: Healthgrades Report to the Nation*, which evaluates hospital performance at over 4,500 hospitals nationwide for 31 of the most common inpatient procedures and conditions. Saint Francis ranks among the top 5% nationally in Coronary Interventional Procedures, Overall Orthopedic Services, and, for the second year in a row, Joint Replacement; and the top 10% for Spine Surgery. (October 2013)

The LeapFrog Group "A" Score – Saint Francis Hospital and Medical Center has received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. The Hospital Safety Score℠ for fall 2013 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. This is the fourth consecutive "A" rating received by Saint Francis from The Leapfrog Group. The grades are derived from expert analysis of publicly available data using 28 evidence-based, national measures of hospital safety. Saint Francis was one of three hospitals in the state to receive an "A" grade from Leapfrog in the rating for fall 2013, and one of only two to receive the honor twice this year. Among Connecticut hospitals, 7 received a "B," 15 received a "C," one received a "D," and one received an "F." (October 2013)

Daily Point of Light Award – Points of Light, the world's largest volunteer organization, named Michael R. Bourque, M.D., a senior OB/GYN physician at Saint Francis Hospital and Medical Center, a *Daily Point of Light Award* honoree for his leadership role on the "Blue Team," a medical missionary team with International Medical Missions of Saint Francis Hospital and Medical Center. Dr. Bourque is the recipient of this prestigious award honoring his commitment to bringing first-class medical services to those in need. (October 2013)

CareChex® – Saint Francis Hospital and Medical Center was recognized by CareChex®, a division of Comparion Medical Analytics, for patient safety and medical excellence achievements in numerous categories in its 2014 hospital quality award rankings. Saint Francis ranked #1 in Connecticut in 24 clinical and surgical areas for patient safety and medical excellence. In the area of Patient Safety: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Coronary Bypass Surgery, Gastrointestinal Care, Gastrointestinal Hemorrhage, Interventional Coronary, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, and Major Orthopedic

Surgery. For Medical Excellence: Overall Hospital Care, Overall Surgical Care, Coronary Bypass Surgery, Gastrointestinal Care, General Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Orthopedic Care, Major Orthopedic Surgery, Spinal Fusion, and Spinal Surgery. (October 2013)

IBCLC Care Award – Saint Francis Hospital and Medical Center received *IBCLC Care Award* from the International Board of Lactation Consultant Examiners® (IBLCE®) and International Lactation Consultant Association® (ILCA®) for excellence in lactation care. The recognition is given to facilities that: have a lactation program that is available 5-7 days a week; provided recent breastfeeding training for medical staff; and have recently completed activities that help protect, promote, and support breastfeeding. (August 2013)

American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award* – Saint Francis Hospital and Medical Center received the *Get With The Guidelines®–Heart Failure Gold Plus Quality Achievement Award* from the American Heart Association. The recognition signifies that Saint Francis has reached an exceptional goal of treating heart failure patients according to the guidelines of care recommended by the American Heart Association/American College of Cardiology. This marked the second consecutive year that Saint Francis has been recognized with the *Gold Plus* quality achievement award. Saint Francis was one of just three hospitals in Connecticut to receive *Gold Plus* recognition that year. (August 2013)

Consumer Reports – *"Best Hospital for Surgery"* – Saint Francis Hospital and Medical Center was one of two statewide hospitals to receive the highest ranking available by Consumer Reports Health Ratings Center in their *"Best Hospitals for Surgery"* Ratings report appearing in the September 2013 issue of Consumer Reports magazine. Of the almost 2,500 hospitals rated by Consumer Reports in all 50 states plus Washington, D.C. and Puerto Rico, Saint Francis Hospital and Medical Center received not only the highest overall surgery Rating in state rankings, it was also named among the top five U.S. hospitals that perform the safest knee and hip replacement surgeries, and the only hospital rated in these two categories in the state. (July 2013)

Most Wired – 2013 – Saint Francis Hospital and Medical Center was recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2013 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. Named to the *Most Wired* list for the fourth consecutive year, Saint Francis is one of only eight hospitals in Connecticut to be recognized on the *Most Wired* list that year. (July 2013)

U.S. News & World Report – Best Hospitals – Saint Francis Hospital and Medical Center ranked #3 in the state of Connecticut and #2 in the Hartford metro area, gaining high scores in eight specialties and in patient safety, in the *U.S. News & World Report* ranking of Best Hospitals in the U.S. Top performing specialties at Saint Francis listed in the *U. S. News & World Report* annual rankings of Best Hospitals include Cardiology and Heart Surgery, Diabetes and Endocrinology; Gastroenterology and GI Surgery, Geriatrics, Nephrology, Orthopedics, Pulmonology and Urology. (July 2013)

The LeapFrog Group "A" Score – For the third consecutive year, Saint Francis Hospital and Medical Center was again honored with an "A" Hospital Safety Score by The Leapfrog Group, an independent national nonprofit run by employers and other large purchasers of health benefits.

The A score was awarded in the latest update to the Hospital Safety Score℠. The A, B, C, D or F scores are assigned to U.S. hospitals based on preventable medical errors, injuries accidents, and infections. The Hospital Safety Score was compiled under the guidance of experts on patient safety and is designed to give the public information they can use to protect themselves and their families. (May 2013)

HealthGrades® Patient Safety Excellence Award™ – Saint Francis Hospital and Medical Center received the *Healthgrades 2013 Patient Safety Excellence Award™*, according to Healthgrades, the leading online resource that helps consumers search, evaluate, compare and connect with physicians and hospitals. The distinction placed Saint Francis within the top 5% of all hospitals for its excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays. This was the third consecutive year that Saint Francis received this prestigious award. Saint Francis was the only hospital in Connecticut to achieve this distinction in 2013. (April 2013)

Practice Greenhealth/Partner for Change Award – for leadership in prioritizing our environmental performance and demonstrating our commitment to a higher standard of excellence in sustainability. This is the fifth time Saint Francis earned this distinction. (April 2013)

CareChex – According to a 2011 CareChex national hospital quality study, Saint Francis Hospital and Medical Center was #1 in the State in the category of "Medical Excellence" for: Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Orthopedic Care, Major Orthopedic Surgery, Spinal Surgery, and Trauma Care. Additionally, Saint Francis was #1 in the State for Patient Safety in the areas of: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Major Orthopedic Surgery, Stroke Care, and Trauma Care. (January 2013)

The LeapFrog Group "A" Score – *Saint Francis Hospital and Medical Center* was honored with a second consecutive "A" Hospital Safety Score℠ by The Leapfrog Group, a nationally recognized organization founded by a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers nationwide. Saint Francis was the largest hospital in Connecticut to merit this distinction, and one of only six statewide to receive this recognition. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety records. (November 2012)

Connecticut Breastfeeding Coalition – Saint Francis Hospital and Medical Center received an award of recognition from the Connecticut Breastfeeding Coalition for its contributions to the health of Connecticut's mothers and children through the Connecticut Breastfeeding Initiative 2010-2012. (October 2012)

Healthgrades® – Saint Francis *Care* was listed as #1 in Connecticut for joint replacement outcomes and is one of America's 100 Best Hospitals for Joint Replacement. Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: heart failure, back and neck surgery, stroke, pneumonia, GI bleed, respiratory failure, diabetic

acidosis and coma. This is according to a report from Healthgrades, *American Hospital Quality Outcomes 2013: Healthgrades Report to the Nation*. Healthgrades is the leading provider of information to help consumers make an informed decision about a physician or a hospital. (October 2012)

HAVEN Employer Engagement Award – this award was presented to Saint Francis by the Health Assistance InterVention Education Network (HAVEN). The award recognized employers who, through human resources, employee assistance, and/or occupational health, have developed ways to help employees confront the challenges of physical and mental illness with dignity and compassion. (October 2012)

"I Am Who I Am" – recognized by the Walk In the Light Ministries and by Archbishop Louella Tate as an organization that has helped Hartford become a role model for other cities. (September 2012)

National Air Filtration Association (NAFA) Clean Air Award – recognized for leadership and excellence in the use of high efficiency air filtration products and good maintenance practices. It is presented to those who show an outstanding effort in maintaining a clean and healthy indoor work environment, while reducing overall operating costs. (September 2012)

***Most Wired* – 2012** – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2012)

Connecticut Quality Improvement Award Gold Prize – given to Saint Francis Hospital by the Connecticut Quality Improvement Association for our work in improving the Universal Protocol in our operating room, using the Safe Surgery Checklist. (June 2012)

The LeapFrog Group "A" Score –Saint Francis Hospital and Medical Center was only one of four hospitals in the state to receive an "A" grade on the organization's Hospital Safety Score. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety. (June 2012)

HealthGrades® Patient Safety Excellence Award™ – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates, placing Saint Francis in the top 5% in the nation for patient safety, and the only Connecticut hospital to achieve this distinction. (May 2012)

American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award* – to the Hoffman Heart and Vascular Institute for providing excellent care to heart failure patients. Saint Francis was one of only three hospitals statewide to receive this award. (May 2012)

***Silver Healthy Hospital Award*, Stryker** – for outstanding performance in reducing environmental harm and improving overall hospital quality through medical device remanufacturing and reprocessing. For 2011, Saint Francis saved $235,600 and had a total waste avoidance of 11,900 pounds. (April 2012)

Outcome Excellence Award – the outpatient rehabilitation staff at 95 Woodland Street received this award from Focus on Therapeutic Outcomes (FOTO) for exceeding the predicted national target for outcomes and patient satisfaction over a one-year period. The targets were met for two consecutive years, for both 2010 and 2011. (April 2012)

2012 Top Performer – the inpatient rehabilitation team at Mount Sinai Rehabilitation Hospital received an Outstanding Performance Award from the Uniform Data Systems database for its top ten percent ranking out of 800 programs across the United States. (April 2012)

The Blue Ribbon Award – for the John T. O'Connell Tower presented at the 17th Annual Awards Showcase from the Real Estate Exchange. This is the most significant annual awards event in commercial real estate in Connecticut and a celebration of excellence in the industry. (April 2012)

The BUILDCT 2012 Award – for the John T. O'Connell Tower best new large construction project greater than $10 million from the Association of General Contractors. The award was given to Saint Francis Hospital and Medical Center; TRO/Jung Brannen, the architect and engineer; and Turner Construction Company, the construction manager. (March 2012)

Connecticut Quality Improvement Award Silver Innovation Prize – for the creation of the Connecticut Institute for Primary Care Innovation. (August 2011)

American Heart Association/American Stroke Association Get With The Guidelines Gold Plus Award – for achievement in using evidence-based guidelines in the treatment of stroke patients. (August 2011)

Most Wired – 2011 – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2011)

Community Value Five-Star Hospital – recognized by Cleverly & Associates, a healthcare industry intelligence and education consultancy for value provided to the community, based on financial viability, facility reinvestments, low-cost structures, and high-quality patient care. (July 2011)

Practice Greenhealth Partner for Change with Distinction – for outstanding environmental achievement in healthcare. (April 2011)

HealthGrades® Patient Safety Excellence Award™ – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates. (March 2011)

The American Society for Metabolic and Bariatric Surgery and the Surgical Review Corporation Bariatric Surgery Center of Excellence® Designation – for demonstrating an unparalleled ability to consistently deliver safe, effective, evidence-based care. (March 2011)

Focus on Therapeutic Outcomes, Inc. Outcomes Excellence Award – for exceeding the national average for functional change in the patients treated at the Center for Rehabilitation and Sports Medicine. (March 2011)

The American College of Cardiology Foundation NCDR ACTION Registry Gold Performance Award – for implementing a higher standard of care and reaching the aggressive goal of treating coronary artery disease patients with 85 percent compliance with American College of Cardiology/American Heart Association clinical guidelines and recommendations. (December 2010)

The American Alliance of Healthcare Providers Choice Award – for implementing an excellent healthcare program that successfully results in courteous, compassionate, and caring service to patients, families, and the community. (July 2010)

Most Wired "Most Improved" Award – for the Hospital's level of achievement in business and administrative management, clinical quality and safety, continuum of care, and infrastructure. Based on a survey by *Hospitals & Health Networks* Magazine, McKesson Corporation and the College of Healthcare Information Management Executives. (July 2010)

Practice Greenhealth Partner for Change Award – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2010)

Anthem Blue Cross and Blue Shield Blue Distinction Center for Knee and Hip Replacement – In recognition of clinical excellence in knee and hip replacement surgery. (January 2010)

American Heart Association/American Stroke Association *Get With The Guidelines Gold Plus Performance Achievement Award* – In recognition of implementing excellent care for stroke patients, according to evidence-based guidelines. (January 2010)

U.S. Department of Health and Human Services Silver-2 Medal – In recognition of efforts promoting organ donation. (October 2009)

Employer Support of the Guard and Reserves Program – Connecticut Above and Beyond Award for support of Hospital employees who are members of National Guard and Reserves. (July 2009)

Practice Greenhealth Partner for Change Award – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2009)

ENERGY STAR Label – for superior energy efficiency and environmental protection. Awarded by the U.S. Environmental Protection Agency. Saint Francis was previously awarded ENERGY STAR labels in 2003 and 2006. (April 2009)

Connecticut Breastfeeding Coalition Breastfeeding Friendly Employer Award – Given for Saint Francis' efforts in supporting breastfeeding by working mothers. (January 2009)

American Stroke Association Get with the Guidelines℠ Silver Achievement Award – Given in recognition of Saint Francis' commitment and success in implementing a higher standard of care for stroke patients. To achieve the GWTG-Stroke Silver Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 12 months. (December 2008)

UnitedHealthcare Premium® Specialty Center for Total Joint Replacement – Given with the designation of ***One Star*** and ***Higher Efficiency***. The program uses national industry standards, medical specialty society and consensus standards to evaluate specialty center programs focused on total joint replacement for the purpose of advancing safe, timely, effective, efficient, equitable and patient-centered care. (September 2008)

American Alliance of Healthcare Providers Hospital of the Year – Top 10 Finalist in 2008 Hospital of the Year Awards, which recognizes the country's most consumer-friendly hospitals. (August 2008)

HealthGrades® 2009 Spine Surgery Excellence Award – This award places Saint Francis among the top 10 percent of hospitals nationwide for spine surgery. (July 2008)

2008 Most Wired Survey and Benchmarking Study – Most Improved Award for information technology enhancements in the survey conducted by *Hospitals & Health Networks* magazine in conjunction with Accenture, McKesson Corp. and the College of Healthcare Information Management Executives. (July 2008)

Connecticut Quality Improvement Award Silver Innovation Prizes – Three awards for projects that streamlined critical areas of healthcare: the treatment of heart attacks, transferring patients from the Emergency Department to nursing units, and vaccinating staff against season influenza outbreaks. (July 2008)

American Stroke Association Get With the Guidelines℠ – Stroke Bronze Performance Award – for Saint Francis' commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations. To achieve the GWTG-Stroke Bronze Performance Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 90 days. (May 2008)

Practice Greenhealth Partner for Change Award – for working to reduce mercury, reduce waste and prevent pollution. Presented by Practice Greenhealth, formerly Hospitals for a Healthy Environment (H2), a source of environmental solutions for the healthcare industry. The award honors organizations creating healthy, healing environments committed to eliminating mercury, reducing pollution and recycling waste. (May 2008)

2008 Alliance Innovation Award – Saint Francis Hospital and Medical Center was named an *Alliance Innovation Award* winner by the Alliance of Independent Academic Medical Centers (AIAMC). The award was presented to Saint Francis for its demonstrated leadership in utilizing graduate medical education as a key driver to improve quality, patient safety, and the cost-effectiveness of care. These creative and innovative approaches to medical education and research have resulted in better patient outcomes. (April 2008)

American Alliance of Healthcare Providers 'Hospital of Choice' Award for First Quarter of 2008 – for consumer friendliness and unparalleled commitment to good citizenship and community service, based on a review of public information, Web site, news releases, announcements, phone surveys of Hospital staff and application review. (April 2008)

Verispan 100 Most Highly Integrated Healthcare Networks Best of the Rest – a Tier 2 category rating for integrated healthcare networks based on eight categories: integrated technology, contractual capabilities, outpatient utilization, financial stability, service and access, hospital utilization and physicians. (February 2008)

United Healthcare Premium Specialty Center – for cardiac care, spine and total joint replacement surgery. The designations signify that Saint Francis has met rigorous quality criteria based on nationally recognized medical standards and expert advice. They are based on detailed information about specialized training, practice capabilities and proficiencies submitted by Saint Francis to United Healthcare. (January 2008)

CQIA Silver Innovation Prize – for being early adopters of bar code point of care (BPOC) technology to prevent errors during medication administration. BPOC systems use a bedside computer and a variety of clinical information systems to cross check bar codes that are printed on patient wristbands with those bar codes printed on medications. In addition to new bedside technology, the BPOC involved an extensive process within the Pharmacy Department. All 2,800 inventoried products required bar code recognition by the Hospital's clinical information system. In the first six months after implementation, 75 percent of inpatient areas were using this technology and 350,000 medication doses had been bar coded. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (October 2007)

U.S. Department of Health and Human Services Medal of Honor – for achieving at least a 75 percent organ donation rate among eligible patients. This was the third year in a row that Saint Francis received this award. Saint Francis is the only hospital in Connecticut and Western Massachusetts to receive the medal three years in a row. (October 2007)

AHA Nova Finalist – Hartford Regional Lead Treatment Center and Lead Safe House Program, which are based at Saint Francis Hospital and Medical Center, named one of ten finalists for the American Hospital Association's Nova Award, which recognizes programs that improve community health status and are collaborative in nature. The Hartford Regional Lead Treatment Center serves patients both at Saint Francis and the Connecticut Children's Medical Center. (August 2007)

Blue Center of Distinction – designated a *Blue Center of Distinction for Cardiac Care* by the Blue Cross and Blue Shield Association. The nationwide program recognizes those hospitals that meet stringent quality criteria, as established by expert physician panels and national organizations. *Blue Distinction Centers* are required to provide a full range of cardiac services, including inpatient care, cardiac rehabilitation, angioplasty and cardiac surgery. (June 2007)

Hospitals for a Healthy Environment – received the Partners for Change Award in recognition of achievements in improving environmental performance. Also received the Making Medicine Mercury-Free Award for eliminating the use of mercury in medical devices. Hospitals for a

Healthy Environment (H2E) is an independent, not-for-profit organization founded by the American Hospital Association, the Environmental Protection Agency, Health Care Without Harm and the American Nurses Association. H2E is focused on improving healthcare environmental performance. (May 2007)

Five-Star Hospital – recognized as a Community Value Provider by Cleverly + Associates, a Columbus, Ohio, healthcare financial consulting firm. Based on the Community Value Index™, a proprietary index that offers a measure of the value that a hospital provides to its community based on financial strength and reinvestment, cost of care and pricing. (April 2007)

The President's Volunteer Service Award – for the service of more than 700 individuals who volunteered at the Hospital in 2006, contributing over 67,400 hours of service to Saint Francis. Presented by the President's Council on Service and Civic Participation on behalf of President George W. Bush to recognize the best in the American spirit and encourage Americans to contribute to their communities through volunteer service. (January 2007)

CareScience Select Practice National Quality Leader – for excellence in overall hospital quality and efficiency. The award placed Saint Francis among the top 1 percent of performers across 4,500 acute care hospitals in the United States as identified by CareScience, a hospital consulting firm. It was based on 16 clinical indicators for both quality and efficiency. (November 2006)

ENERGY STAR Label – for prudent energy management strategies and proven technologies. Awarded by the U.S. Environmental Protection Agency and U.S. Department of Energy. Saint Francis was first awarded an ENERGY STAR label in 2003. (November 2006)

eHealthcare Strategy & Trends Silver Award – in the category "Best Rich Media" in the Physician/Clinician-Focused Site class for the Hospital's web site Grand Rounds Online feature. Since their introduction in April, 15 Grand Rounds presentations were made available to physicians online. After viewing a presentation online, physicians are able to obtain Continuing Medical Education credit by successfully completing a short quiz. (November 2006)

U.S. Department of Health and Human Services Medal of Honor – for achieving at least a 75 percent organ donation rate among eligible patients. This was the second year in a row that Saint Francis received this award. In the most recent reporting period, Saint Francis secured permission from family members for 11 organ donations out of 13 potential donors. Saint Francis was just one of two hospitals in Northern Connecticut and Western Massachusetts to receive the medal this year. (October 2006)

HealthGrades® Orthopedic Surgery Excellence Award – for superior clinical outcomes in the ninth annual *Hospital Quality in America* study. This award placed Saint Francis among the top 10 percent of hospitals nationwide for orthopedic care. (October 2006)

Leapfrog Top 50 Hospitals – for meeting the quality and safety standards of the Leapfrog Group, a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers. Saint Francis was the only hospital in Connecticut to achieve this distinction. Leapfrog identifies its "Top Hospitals" based on their implementation of practices with the greatest life-saving potential, including computerized physician order entry

(CPOE), ICU physician staff, evidence-based hospital referral and the Leapfrog Safe Practices Score. (October 2006)

2006 BEACON Medical Technology Award – for the Hospital's significant investment in advanced technology in the acquisition of the CyberKnife® stereotactic radiosurgery system. The award was presented by the Biomedical Engineering Alliance & Consortium (BEACON), a regional trade association for the advancement of new medical technology. It recognizes innovative approaches that help Connecticut establish a leadership position in the field of medical technology. (October 2006)

Sacred Heart University College of Education and Health Professions 2006 Community Partner Award – for collaboration with the College's Nursing Department to develop and implement the R.N. to B.S.N. program offered at Saint Francis Hospital and Medical Center. This was the first year that the award was given to an individual or organization who has demonstrated exceptional collaboration to further the educational goals and mission of the College. Saint Francis was one of two recipients honored that year. (October 2006)

HealthGrades® Third Annual Patient Safety in American Hospitals Study – for best performing hospitals for overall patient safety. Saint Francis was one of 238 hospitals identified as reaching the top 15 percent nationwide for patient safety. This award was presented by HealthGrades, a healthcare ratings company. As a category, Medicare patients at these top 15 percent hospitals experienced patient safety incidents, on average, 43.27 percent less often than patients at the bottom 15 percent of all hospitals. (October 2006)

CQIA Silver Innovation Prize – for a project that optimized care in patients with congestive heart failure (CHF). Taking note of the fact that each year nearly 900 patients are admitted to the Hospital with CHF, the Congestive Heart Failure Service decided to establish Connecticut's first dedicated unit to provide comprehensive care for CHF patients. Outcomes for patients treated on the CHF unit have been demonstrably better than those of other CHF patients. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (July 2006)

Solucient 100 Top Hospitals® Performance Improvement Leader – for improving faster and more consistently than its peer hospitals across the nation. Nine performance measures were examined including risk adjusted mortality and complications, average length of stay, expenses, profitability, cash-to-debt ratio, growth in percent of community served, tangible assets and risk adjusted patient safety index. Saint Francis was recognized as one of the hospitals that achieved the fastest rate of consistent annual clinical and organizational improvement over a five-year period. (April 2005)

Solucient 100 Top Hospitals® – for setting benchmarks for the industry in such areas as quality of care, efficiency, financial performance, growing community service and patient safety. This marked the seventh time that Saint Francis was named to the prestigious list of the nation's Top 100 hospitals. At the time, Saint Francis was the only hospital in Connecticut to be named to the Top 100 list on seven or more occasions. (February 2005)

Solucient 100 Top Hospitals® – for setting performance benchmarks across four critical areas: quality of care, operational efficiency, financial performance and adaptation to the environment. This marked the sixth time that Saint Francis had been named to the prestigious

list. At the time, Saint Francis was the only major teaching hospital to be named to the Top 100 list on six occasions. (May 2004)

Solucient Performance Improvement Leader – for developing consistent and effective organization-wide performance improvement across critical measures at a faster rate than other U.S. hospitals between 1997 and 2001. Those measures include quality of care, operational efficiency and financial performance. Among 123 major teaching hospitals included in the study, Saint Francis' cumulative scored placed it in the 99th percentile. This signifies that Saint Francis' rate of improvement over the five years was higher and more rapid than 98 percent of the other major teaching hospitals studied by Solucient. (March 2004)

EXHIBIT 10

RESOLUTIONS TO BE CONSIDERED
AT
A SPECIAL MEETING OF THE BOARDS OF DIRECTORS
OF
SAINT MARY'S HEALTH SYSTEM, INC.
AND
SAINT MARY'S HOSPITAL, INC.
TO BE HELD
ON
THURSDAY, SEPTEMBER 17, 2015

WHEREAS, Saint Mary's Health System, Inc. ("SMHS"), has been in negotiations with Saint Francis Care, Inc. ("SFC") and Trinity Health Corporation ("Trinity Health"), relating to a certain Transfer Agreement by and among SMHS, Saint Mary's Hospital, Inc. ("SMH"), and Trinity Health (the "Transfer Agreement"), pursuant to which SFC (which will become the New England Regional Health Ministry ("NE-RHM") following completion of its transaction with Trinity) will become the sole corporate member of SMHS and serve as SMHS's parent (the "Transaction"; capitalized terms used but not defined herein shall have the meanings ascribed to them in the Transfer Agreement);

WHEREAS, the Board of Directors of SMHS and the Board of Directors of SMH (together, the "Boards") have reviewed from a financial, business, healthcare, operational, strategic and community perspective the proposed Transaction and having given due consideration to all matters that the Boards believe are necessary or appropriate to enable the Boards to reach a fully informed decision as to the advisability of the Transaction, deem it in the best interest of SMHS and SMH to consummate the Transaction and to enter into and perform their respective obligations under the Transfer Agreement and the Transaction Documents.

NOW THEREFORE, it is hereby:

RESOLVED: That the Boards believe it to be advisable and in the best interests of SMHS and SMH to consummate the Transaction.

RESOLVED: That SMHS and SMH enter into the Transfer Agreement, in substantially the form presented to the Boards and attached hereto as Exhibit A, and that the President and Chief Executive Officer of SMHS and SMH, respectively (collectively, the "Authorized Officer") be, and hereby is, authorized and directed to negotiate, execute and deliver in the name of SMHS and SMH the Transfer Agreement with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH respectively, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority thereunder; and be it further

RESOLVED: That SMHS and SMH enter into such applications, licenses, registrations, agreements, instruments, documents, and all such other Transaction Documents as such Authorized Officer may deem necessary or advisable to effectuate the Transaction and that such Authorized Officer be, and hereby is, authorized to negotiate, execute and deliver in the name of SMHS and SMH, respectively all such applications, licenses, registrations, agreements, instruments, documents and all such other Transaction Documents with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH, respectively, in connection with obtaining all regulatory approvals, licenses, permits, consents, certificates, determination letters or other authorizations necessary or advisable to consummate the Transaction, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder; and be it further

RESOLVED: That such Authorized Officer be, and hereby is, authorized to complete, execute and deliver in the name of SMHS and SMH, respectively such which such Authorized Officer in his sole discretion deems necessary or appropriate and in the best interests of SMHS and SMH , the execution and delivery of the foregoing to be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder, and be it further

RESOLVED: That the officers of SMHS and SMH be, and each acting singly hereby is, authorized and empowered, in the name and on behalf of SMHS and SMH, to take or cause to be taken any and all actions and to execute and deliver or cause to be executed and delivered any and all agreements, resolutions, documents, certificates, reports and regulatory or other notices or filings, and to incur any and all fees and expenses necessary or appropriate in the opinion of such officer to effect the foregoing resolutions, which action or execution and delivery thereof shall constitute conclusive evidence of the authorization and approval of such action by SMHS and SMH; and be it further

RESOLVED: That all actions heretofore taken by any officer or director of SMHS and SMH in connection with or otherwise in contemplation of the matters contemplated by the foregoing resolutions be, and they hereby are, authorized, approved, ratified and confirmed in all respects.

Saint Mary's
HEALTH SYSTEM

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
Special Boards of Directors Meeting
Thursday, September 17, 2015

Present	Staff Present	Excused
Robert J. Mazaika, Chair	Robert J. Anthony, Esq. (via phone)	Michael O'Brien
Rev. Monsignor James Coleman (via phone)	Ralph Becker	Jim Smith
Eric Albert (via phone)	Victoria Cipriano	
S. Mark Albini, M.D.(via phone)	Steve Schneider, M.D.	
Joseph Carlson (via phone)		
Garrett Casey (via phone)		
Stephen R. Griffin, Esq.		
Robert Gumbardo, M.D. (via phone)		
Michael Karnasiewicz, M.D. (via phone)		
Sister Dolores Lahr, CSJ		
Angela Mattie		
Joseph Mengacci, Esq. (via phone)		
Richard Pugh (via phone)		
Felix Rodriguez (via phone)		
Robert Roscoe (via phone)		
Christine Sullivan, Esq. (via phone)		
James Uberti, M.D.		
Chad W. Wable		

I. **Call to Order & Opening Prayer**
Upon provision of due notice, the meeting of the Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. Boards of Directors was called to order by the Chairman, Robert J. Mazaika, at 7:00 a.m. with the opening prayer offered by Monsignor J. Coleman.

II. **Report of the Chairman**
Report of Board Taskforce
Mr. Mazaika advised that a revised Transfer Agreement and Board Resolutions were available via the SMHS Board Portal. He asked the Board if anyone had any questions or comments.

Action: Motion made and seconded to approve the transfer of SMHS and SMH membership to Trinity Health through the New England Regional Health Ministry and to change our juridical person to Catholic Health Ministries. Attorney Joseph Mengacci opposed the vote.

Mr. Mazaika reminded everyone to keep this information confidential for one more day. A formal signing of the documents will be held tomorrow, Friday, September 18, 2015, and at that time an announcement will be released to the public. Mr. Wable advised that Rick O'Connell, Executive Vice President of the East Group, and Chris Dadlez, Saint Francis Care, will attend the signing at 12 noon in the Auditorium.

Dr. Uberti congratulated and commended the Taskforce members past and present for their many hours of work.

Mr. Wable advised that the CON process is underway and will file legal notice immediately and anticipate filing a complete CON by November 30th.

III. **Announcements/Relevant Readings/Agenda Items**
Mr. Mazaika advised that the next SMHS/SMH Board Meeting will be held on September 24, 2015, Thursday: 7:00 a.m. – 9:00 a.m. in the Archbishop Daniel A. Cronin Boardroom.

IV. **Adjournment**
There being no further business, the meeting adjourned at 7:08 a.m.

Respectfully submitted,

Victoria Cipriano
Recording Secretary

Approved by,

Robert J. Mazaika
Chairman of the Board

EXHIBIT 11

Town	Discharges	% of Total
PLANTSVILLE	42	0.36%
BETHLEHEM	67	0.58%
MORRIS	14	0.12%
THOMASTON	156	1.34%
WATERTOWN	621	5.34%
WOODBURY	126	1.08%
BEACON FALLS	69	0.59%
CHESHIRE	184	1.58%
MIDDLEBURY	176	1.51%
NAUGATUCK	1,068	9.18%
OXFORD	78	0.67%
PROSPECT	389	3.34%
WATERBURY	6,837	58.75%
WOLCOTT	727	6.25%
PLYMOUTH	73	0.63%
SOUTHBURY	242	2.08%
Other	768	6.60%
Total	11,637	100.00%

EXHIBIT 12

STATE OF CONNECTICUT

Department of Public Health

License No. 000055

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Saint Mary's Hospital, Inc., Waterbury, CT, d/b/a **Saint Mary's Hospital, Inc.** is hereby licensed to maintain and operate a General Hospital.

Saint Mary's Hospital, Inc. is located at **56 Franklin Street, Waterbury, CT**

32 Bassinets
347 General Hospital Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2015

Satellites:
Saint Mary's Department of Behavioral Health Care Services, 100 Jefferson Square, Waterbury, CT
Saint Mary's Hospital Urgent Care Center, 799 New Haven Road, Naugatuck, CT 06770
Saint Mary's Urgent Care Center, 503 Wolcott Road, Wolcott, Ct 06716
Naugatuck Valley Surgical Center, 160 Robbins Street, Waterbury, CT 06708
Saint Mary's Hospital Family Health Center, 95 Scovill Street, Waterbury, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

FRANKLIN MEDICAL GROUP, PC
799 NEW HAVEN ROAD
NAUGATUCK, CT 06770

LABORATORY DIRECTOR

PETER JACOBY, MD

CLIA ID NUMBER

07D1020707

EFFECTIVE DATE

12/30/2013

EXPIRATION DATE

12/29/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
Centers for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

79 Certs1 120313

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

07/21/2015 11:42AM (GMT-04:00)

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS	CLIA ID NUMBER
POND PLACE PEDIATRICS 166 WATERBURY RD, SUITE # 202 PROSPECT, CT 06712	07D2043173
LABORATORY DIRECTOR	EFFECTIVE DATE
KAREN ELIZABETH KENNEDY DIR	06/28/2014
	EXPIRATION DATE
	06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

92 Certs1_060314

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CLIA ID Number: 07D2043173
POND PLACE PEDIATRICS
56 FRANKLIN STREET
LAWLOR BLDG, 1 ST FLOOR
WATERBURY, CT 06706

STATE AGENCY ADDRESS AND PHONE NUMBER:

CLIA LAB PROGRAM/DEPT OF PUBLIC HEALTH

410 CAPITOL AVENUE, MS#12-HSR
PO BOX 340308
HARTFORD, CT 06134-0308
(860)509-7400

LABORATORY MAILING ADDRESS:

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

FRANKLIN MECICAL GROUP PC
166 WATERBURY ROAD
PROSPECT, CT 06712

CLIA ID NUMBER
07D1106888

EFFECTIVE DATE
10/23/2013

LABORATORY DIRECTOR
MARIE P LIVIGNI

EXPIRATION DATE
10/22/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

152 Certs_092413

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

WOLCOTT INTERNAL MEDICINE
503 WOLCOTT ROAD
1 ST FLOOR
WOLCOTT, CT 06716

CLIA ID NUMBER

07D2043175

EFFECTIVE DATE

06/28/2014

LABORATORY DIRECTOR

LAURA C BRENES DIRECTOR

EXPIRATION DATE

06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

93 Certs1_060314

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CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS	CLIA ID NUMBER
FRANKLIN FACULTY PRACTICE DBA FRANKLIN MEDICAL GROUP 133 SCOVILL ST, STE 102 WATERBURY, CT 06706	07D1028439
LABORATORY DIRECTOR	**EFFECTIVE DATE**
	07/23/2014
JASON OUELLETTE MD DIRECTO	**EXPIRATION DATE**
	07/22/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

297

103 Certs1_062414

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
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EXHIBIT 13

PROFESSIONAL STATEMENT

A PASSIONATE, CONTEMPORARY AND HIGHLY ACCOUNTABLE LEADER DEDICATED TO BUILDING ESSENTIAL RELATIONSHIPS WITHIN THE MEDICAL COMMUNITY AND BROADER COMMUNITY IN ORDER TO COME TOGETHER AS A TEAM TO TRANSFORM HEALTHCARE INTO A CONSUMER-ORIENTED SYSTEM OF REGIONAL HEALTHCARE SERVICES WITH THE RIGHT PATIENT RECEIVING THE RIGHT CARE IN THE RIGHT LOCATION RESULTING IN A VERY GOOD PATIENT EXPERIENCE THAT IS SUBSTANTIALLY BETTER QUALITY CARE, TRUSTED AND SAFE WHILE DRAMATICALLY REDUCING THE TOTAL COST OF CARE OVER TIME.

EXPERIENCE

Saint Mary's Health System, Inc., Waterbury, CT

Integrated network of healthcare services including Saint Mary's Hospital (347 beds), a Level 2 Trauma Center and NICU, Saint Mary's Hospital Foundation, Saint Mary's Indemnity Company, Naugatuck Valley Surgical Center, Harold Leever Regional Cancer Center, Heart Center of Greater Waterbury, Diagnostic Radiology of Southbury, Naugatuck Valley MRI, and Franklin Medical Group.
STATS: 12,000 admissions, 70,000 ED visits, 18,000 surgeries, 3 residency/teaching programs, $280 million in net revenues, 400 active members of the medical staff and 2,000 staff.

President and Chief Executive Officer (2008-present)

Major Accomplishments:

Growth and Finance

- ✓ One of seven hospitals in CT to achieve a positive five-year average operating margin.
- ✓ Increased DCOH from less than10 days to over 70 days.
- ✓ Lowest cost hospital in CT based on total cost per discharge.
- ✓ Established largest robotic surgery program in the region.
- ✓ Operate the largest freestanding surgical center in CT.
- ✓ Opened first community hospital based open heart and angioplasty program in CT.
- ✓ Aligned three physician groups into one large, integrated 100 provider multi-specialty group.
- ✓ Consolidated pediatric services in Waterbury with Connecticut Children's Medical Center establishing a hospital within a hospital at Saint Mary's Hospital.
- ✓ Established a hospital within a hospital partnership with VITAS for an inpatient hospice.
- ✓ Led the Board through an affiliation process resulting in multiple options for a transaction.
- ✓ Led the establishment of a wholly owned insurance company and risk management program.

Service and Quality

- ✓ Received the national quality performance award by the Joint Commission.
- ✓ One of Ten hospitals nationally selected to receive an ACC Patient Navigator Program Grant.
- ✓ Improved inpatient and ambulatory surgery HCAHPS more than 50 percentile points.
- ✓ Reduced patient falls and hospital acquired infection from over 200 to less than 100.
- ✓ Achieved top decile nationally for over 77% of all reportable CMS Core Measures.
- ✓ Achieved recognition five consecutive years by AHA *Get with the Guidelines* as a Gold Award Hospital for treatment of heart failure, MI and stroke.
- ✓ Achieved Consumer Reports safest hospital in CT 2013 and 2014.
- ✓ Recognized as a Top 100 Community Value Leadership Award Winner by Cleverley and Assoc.

Executive Vice President, Strategy Development and System Operations (2008)

Vice President of Ambulatory Operations and Business Development (2003-2008)

Responsible for strategic management, business development and community relations activities for the Health System. Responsible for all outpatient operations within the Health System with responsibility for growing market share, achieving Balanced Scorecard results and leading change within the organization.

Major Accomplishments:

- ✓ Served as a member of the senior management team responsible for successfully implementing a $24M financial turnaround plan.
- ✓ Led the planning, development and CON process for the establishment of a collaborative open heart and cardiac angioplasty program.
- ✓ Successfully recruited several physicians including several internists, breast surgeons, neurosurgeon, neurologist, cardiologists and a cardiothoracic surgical team.
- ✓ Led the development of a new Stroke Program consistent with the American Stroke Association *Get with the Guidelines* program.
- ✓ Led the development of a Bariatric Surgical Program in pursuit of accommodation as a Center of Excellence by the ASMBS and SRC.
- ✓ Established comprehensive community benefits program.
- ✓ Led the development of a comprehensive women's & breast services strategy including a new breast surgical practice and the development of diagnostic services.
- ✓ Led redesign of ambulatory care delivery system including six new outpatient facilities and enhanced technology resulting in over $1.0 million in annual incremental income.
- ✓ Introduced new patient advocacy program including patient rounding, real-time recovery process and a functional reporting system.
- ✓ Led team responsible for coordinating and developing an affiliation strategy including assessing local consolidation and national partnership options.
- ✓ Led the redesign of a primary care network of hospital sponsored and private practices.
- ✓ Led the establishment of the first freestanding hospital-owned MRI Center in Waterbury.

Corporate Director of Strategic Planning and Business Development (2002-2003)

Responsible for leading the Board and Senior Management through a comprehensive strategic planning process resulting in the first system-wide long range strategic plan including master facility, medical staff development, quality improvement, image improvement, information systems and long range financial plans. Provided management support for marketing, community relations, medical staff development, imaging services, health information management, plant operations and support services. Reported directly to President & CEO.

Major Accomplishments:

- ✓ Lead annual strategic planning process including annual update of a five year strategic plan.
- ✓ Designed and administered a Balanced Scorecard for enhancing relationships, clinical effectiveness and improving operating performance.
- ✓ Led the completion of a comprehensive master facility plan including optimizing the current facility and long term options for rebuilding in place and new construction.
- ✓ Led the completion of the medical staff development plan including a community needs assessment, physician satisfaction survey and the establishment of physician recruiting policies, procedures and strategies.
- ✓ Designed and implemented an image improvement strategy including the redesign of the marketing and community relations functions resulting in dramatically improved brand identity and consumer perception.
- ✓ Led redesign of imaging services including establishment of a new professional services agreement with a local radiology group.
- ✓ Led team responsible for improved charge capture and front-end revenue cycle improvement.

Monongalia Health System, Inc., Morgantown, WV

Integrated network of healthcare services including Mon General Hospital, The Foundation of Mon General Hospital, MonHealthcare Equipment & Supplies, Monongalia EMS, The Village at Heritage Point, Healthworks Rehab & Fitness, Care Partners, HealthSouth Rehab Hospital.

Director of Strategic Planning and Business Development (2000-2002)

Strategic Analyst (1999-2000)

Post-graduate Fellowship, Healthcare Administration (1999)

West Virginia University, Morgantown, WV

Instructor, Community Health Education (1998-1999)

EDUCATION

West Virginia University, Morgantown, WV
Master of Business Administration, August 2002
Master of Science in Community Health Education, December 1999
Master Certificate in Healthcare Administration, December 1999
Bachelor of Science in Biology, May 1998

PROFESSIONAL AFFILIATIONS/CERTIFICATIONS
American College of Healthcare Executives – Fellow
American Hospital Association, Metropolitan Governing Board
Connecticut Hospital Association – Board of Directors
CT Chapter American College of Healthcare Executives – Board of Directors
Certified High Reliability Trainer through HPI
Six Sigma Green Belt with Lean and Workout Training through Juran Institute

COMMUNITY SERVICE
United Way of Greater Waterbury, Board of Directors, Chairman (2010-2012)
Greater Waterbury YMCA, Board of Directors
Waterbury Regional Chamber of Commerce, Board of Directors
Saint Bridget's School, Board of Directors
Rezziliant, Inc., Board of Advisors (2005-2010)
Visiting Nursing Association, Board of Directors (2004-2007)

AWARDS AND HONORS
Connecticut Magazine 40 under 40 Award recipient (2011)
Modern Healthcare Magazine "Up & Comers" Award recipient (2010)
American College of Healthcare Executives, Early Careerist Award, Connecticut Chapter (2006)
West Virginia University, Varsity Football
- Big-East Conference Scholar-Athlete first team (1994-1997)
- Ira E. Rogers Award for high leadership, academic qualities, and football performance (1997)

Ralph W. Becker

255 Hobart St, Southington, CT 06489
rwbecker@cox.net
Cell: 203-537-5412
Home: 860-426-9207

1985 – 2013 Midstate Medical Center, Meriden, Connecticut www.midstatemedical.org
Midstate is a 144 bed hospital with $200 million in annual net revenues.
Midstate is part of the Hartford Healthcare System.

Vice President and CFO
Responsible for all financial reporting, budgeting, financings, managing managed care, revenue integrity / enhancement, physician financial agreements and ventures. Currently oversee Finance, Accounting, Budgeting; have previously overseen Health Information Management (Medical Records), Materials Management, and Service Access. Also, Chair the hospital's Risk Management Committee. Report to the hospital CEO and the CFO for the system.

Significant accomplishments:
Instrumental in maintaining consistently positive operating results in a changing environment for more than a decade. Feasibility analysis, Certificate of need preparation, and financial oversight of a hospital merger, then subsequent construction of a new hospital at a new location. Coordinated feasibility analysis and financings for multiple building programs (most recently a major expansion within the last 4 years). Established and oversee a multi-disciplinary revenue enhancement (revenue cycle) function (for more than a decade). Responsible for achieving very favorable managed care rates and terms; the hospital's "private payment to cost" ratio averages 1.4 (best in Connecticut) for many years. Helped build a positive relationship with our affiliated physicians. Served on the Board of Directors as CFO of the PHO.

1981- 1985 Ernst & Young (formerly Ernst & Whinney) Hartford Connecticut.
Senior Consultant (health care consulting team).
Oversight or involved with various consulting engagements (including reimbursement, cost reporting, revenue enhancement, feasibility studies).

1974- 1981 Anthem Blue Cross (formerly Blue Cross & Blue Shield of Connecticut)
Positions progressing to Senior Reimbursement Analyst / Auditor.
Oversight or involved in Medicare Audit and Reimbursement functions.

Education:
MBA Finance – University of New Haven, New Haven Connecticut
BS in Finance – Norwich University, Northfield Vermont
Community: Served on Executive Committee and Board of Directors of the Quinnipiac Chamber of Commerce (Wallingford and North Haven Connecticut) for 11 years

CHARLES M. FLINN, FACHE

214 West Chestnut Street - Unit 303
Kingston, New York 12401

(Cell) 845-399-5992
Email: chip.flinn@gmail.com

SUMMARY OF EXPERIENCE:

Highly visible, results-oriented health care executive with 16 years in leadership. Effective communicator with strong clinical, quality and fiscal skills, experienced in change management, the ability to align diverse stakeholders, and develop employee, medical staff and board relations. Strategic, quality-focused leader with distinguished performance in process improvement and system integration utilizing Lean and Six Sigma acumen. Proven abilities include programmatic development leading to a national "number one in overall patient satisfaction" award from The Jackson Group (NRC Picker).

PROFESSIONAL EXPERIENCE:

Executive Vice President-COO — **HealthAlliance of the Hudson Valley, Kingston, NY** — **2009-Present**

Executive Vice President of two long-standing, fiercely competitive community hospitals situated less than 1 mile apart. Under Berger Commission edict, initiated strategy and execution of plan to combine into a financially successful integrated healthcare delivery system.

- Set strategies and goals to achieve financial performance targets over two hospitals, all ambulatory, behavioral health, support and emergency services;
- Completed $22.5M in capital projects, including new ORs, ED, clinical consolidations of nursing units;
- Aligned and rebuilt diverse workforce of 2,400 through training in contemporary management to build one seamless organization;
- Development of clinical integration model for 78 primary care physicians striving towards an ACO model;
- Developed physician-centric Centers of Excellence in Breast Health, Ortho & Vascular Surgery;
- Combined two emergency departments into one 50,000 visit department and accomplished a positive $2M revenue enhancement project while improving organizational throughput;
- Negotiated new annual contracts with EM Group, Radiologists and EMS provider through RFP processes;
- Restructured physician practice model from employed model to private office practice at the critical access hospital – decreased expenses in excess of $320,000;
- Completely re-engineered care delivery model for behavioral health service line turning around a deficit to a $1.2M favorable contribution margin while improving patient outcomes significantly;
- Re-designed, raised funding for and construction of $1.6M oncology infusion, breast health and pre-surgical centers; and
- Awarded HealthGrades Top 5% award for Patient Safety.

Vice Chair, Operating Committee — **Hudson Health Partners, Newburgh, New York** — **2011-Present**

Established in 2012, Hudson Health Partners is a controlled for-profit joint venture corporation linking four Hudson Valley hospital systems into a single, non-asset merged healthcare corporation focused on employee self-insurance, physician centric care management improvements and continuum of care coordination pre- and post hospital. Through contiguous geographic scale, HHP serves Orange, Rockland, Dutchess and Ulster counties, encompassing a scope of 1.1 M in population, 1,200 physicians and collective operating budgets of over $1 billion.

- Quality initiatives and best practices to ensure that residents of the region have access to exceptional care;
- Clinical collaborations including population health and wellness initiatives to enhancement and expansion of care delivery throughout the region;
- Physician Services including recruitment, medical education, Electronic Health Records, and practice management services.
- Hospital services, pilot projects/incubators, clinical care paths and shared support services.
- Enhanced efficiencies gained through population management, group purchasing and sharing of resources to reduce costs.

Vice President-Chief Administrative Officer **Saint Clare's Health System, Denville, NJ** **2005-2009**

Vice President of $300M, multi-campus healthcare system serving a community population exceeding 300,000 in northwest New Jersey. Total 500 licensed beds with direct operational oversight of Nursing (Med/Surg, ED, ICU, OR, L&D, PACU, Oncology, Cardiac Cath and Peripheral labs), Laboratory, Radiology, Cardiology, Respiratory, Endoscopy, Women's Health, Emergency Medical Services and Support Services. Service Line Executive and Champion for Women's Health, Minimally Invasive Orthopedic and Robotic Surgery, Cardiac and Vascular Programs and Inpatient/Outpatient imaging

- Developed of tri-annual strategic plans, including joint ventures with cardiology and vascular surgeons;
- Launch of the Miracles Campaign - a community philanthropic initiative to raise $200M from community, employees and medical staff;
- Constructed $11M mother/child center - the Katena Center - on-time and under budget;
- Partnered with physicians to design and develop a pediatric neuro-epilepsy program and inpatient unit;
- Increased market share of emergency medical services by more than 16% over two-year period;
- Led community and state approvals (DOH, DEP, DEC) for $75MM patient access/parking structure
- Achieved approval for State primary stroke center designation;
- Led organization from concept through completion of $3.8MM interventional labs;
- Improvement of radiology cycle and waiting times by 37% reduction, utilizing Lean Six Sigma methods;
- Opened an Outpatient Imaging Center, $1.9M on-time and on-budget;
- Aggressive efforts to develop a "high-technology/high-touch" culture;
- Planned the region's first 30-minute *'Door to Doctor'* program in the Emergency Department;
- Enhanced medical staff relations (~748 credentialed staff), fostering relationships to partner with administration;
- Purchased and implemented a daVinci Robot for minimally invasive urologic and gynecologic surgery;
- Improved oncology program with enhanced care delivery utilizing Tomo-Therapy radiation in new center of excellence - Cancer Care at Saint Clares;
- Improved financial performance with developed financial dashboards; demonstrated 37% performance increase.

Director, Emergency Services **St, Joseph's Mercy of Macomb Hospital, Clinton Township, Michigan** **2004-2005**

Responsible for daily business operations of Emergency Department with $9M annual budget, 54,000 annual visits, 10,000 of which resulted in admissions. Developed strong leadership of nursing and physicians and liaison with all clinical and non-clinical departments. Managed 30-minute guarantee for patients - 97% efficiency; leading to 85th percentile NRC patient satisfaction.

Executive Director-Patient Access **University of Medicine & Dentistry of New Jersey, Newark, New Jersey** **2002-2004**

Responsible for daily business operations of Emergency Department with $19 Million annual budget, 76,000 ED visits, 13,000 admissions for a 430 bed academic hospital, ACS Accredited Level I Trauma Center. Executive oversight of bed control, out-patient registration and admitting – Matrix Reporting structure.

- Awarded "Runner-Up" for best performance improvement project FY03;
- *"Decreasing Medical Screening Exam-A Pilot Study"* - July 2002;
- Nominated for Modern Healthcare's *"Up and Comer Award"* for significant achievement in healthcare;
- Reduced "missing charts" from ~120/month to <5/month in Q1 FY04 through rapid design process improvement;
- Identified root-causes of unbilled revenue of the outpatient revenue;
- Administrative Champion for MedAptus physician (professional) billing software via "palm" device and wireless network;
- Developed and implemented "balanced scorecard" for performance improvement metrics; and
- Completed design and construction of $14 million renovation of emergency department.

CFO–Department of Surgery **University of Medicine & Dentistry of New Jersey, Newark, NJ** **2002-2004**
Administrative Director **Good Samaritan Hospital Medical Center, West Islip, New York** **1998-2002**

EDUCATION:

Dowling College, Oakdale, New York, Master of Business Administration-Management	2002
St. Joseph's College, Patchogue, New York, Bachelor of Science-Healthcare Administration	2000

PROFESSIONAL AND BOARD MEMBERSHIPS:

American College of Healthcare Executives (ACHE), Fellow	2007
HANYS Chief Operating Officers Committee	2009
NORMET Patient Safety Organization	2010

CHRISTOPHER M. DADLEZ, FACHE

HOME:
9 Cobtail Way
Simsbury, CT 06070
(860) 2167-1648
CDadlez@aol.com

OFFICE:
Saint Francis Hospital and Medical Center
114 Woodland Street, Hartford, CT 06105
(860) 714-5541 Fax (860) 714-7920
CDadlez@stfranciscare.org

SUMMARY

A healthcare career of 30 years successfully leading and managing large, complex organizations.

PROFESSIONAL EXPERIENCE

PRESIDENT AND CHIEF EXECUTIVE OFFICER
Saint Francis *Care*, Inc.
Saint Francis Hospital and Medical Center
(2004 to present)

Saint Francis Hospital and Medical Center has been an anchor institution in North Central Connecticut since its founding in 1897 by the Sisters of Saint Joseph. Licensed for 617 beds, it is one of the largest hospitals in Connecticut and is the largest Catholic hospital in New England. We are a multidisciplinary, leading-edge teaching hospital.

Saint Francis affiliated with Mount Sinai Hospital in 1990 to create a new regional healthcare system. This was the first recorded instance of a merger between a Catholic hospital and a Jewish hospital in United States history. In October 1995, the two institutions completed a formal corporate merger.

A regional referral center, Saint Francis provides sophisticated, contemporary medicine with major clinical concentrations in cardiology, orthopedics, oncology, orthopedics, women's services and rehabilitation. The achievement of excellence is emphasized through centers of excellence, which focus on quality, caring and the dignity of every patient.

Saint Francis has been named a Solucient "Top 100 Hospital" seven times, a "Top 100 Cardiac Program" three times, and a "Top 100 Performance Improvement Hospital" twice. It is also the recipient of the Leapfrog Top 50 Hospitals award and has been recognized by Care Science Top 1% of all hospitals in clinical outcomes.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
CSAHS/UHHS-Canton, Inc.
Mercy Medical Center
(2000-2003)
CSAHS/UHHS, Inc. is the not-for-profit Partnership representing the Sisters of Charity of St. Augustine Health System (CSAHS) and University Hospitals Health System (UHHS) of Cleveland. The Partnership operates Mercy Medical Center in Canton, Ohio and its regional health centers in North Canton, Carrollton, Jackson Township, Louisville, and Dover, Ohio

Responsible for efficient and effective operation and strategic direction of the organization reporting directly to the Partnership Board.

Mercy Medical Center was named a "Top 100 Hospital" for 2001 and 2002, Top 100 Cardiovascular Services Hospital for 2001 and 2002 and a Top 50 U.S. News & World Report Best Hospital for cardiovascular services for 2001 and 2002. In 2001 Mercy received the prestigious AHA Nova Award for innovative community outreach programs. For the last three years Mercy has attained record numbers in admissions, outpatient visits, net revenue and productivity.

CHRISTOPHER M. DADLEZ, FACHE

EXECUTIVE VICE PRESIDENT
Saint Barnabas Health Care System
(1996 to 2000)
Parent company of the largest healthcare provider in New Jersey. This 2 billion-dollar annual revenue company consists of ten acute-care hospitals, one children's hospital, 48 ambulatory centers, 23,000 employees, 4,000 physicians and 450 medical residents.

Member of the Office of the President/Executive Management Committee. Responsible for the strategic direction and centralized management of this dynamic organization. System-wide responsibilities include all clinical integration, development of center(s) of excellence, product line operations, marketing and development, and graduate medical education.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
MID-ATLANTIC HEALTH GROUP
Parent company of Monmouth Medical Center. Monmouth Health Care foundation: Mid-Atlantic Health Care: Monmouth Chemical Dependency Treatment Center, MA Resources and Monmouth Medical Surgi Center, Inc. Merged this holding company with two other organizations to form the new Saint Barnabas Health Care System.

PRESIDENT AND CHIEF EXECUTIVE OFFICER
MONMOUTH MEDICAL CENTER
(1992-1996)
Responsible for the efficient and effective operation and strategic direction for this 526-bed community teaching hospital (with 2,000 FTEs and an operating budget of $170 million). Affiliated with the Medical College of Pennsylvania and Hahnemann University

EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER
SINAI HOSPITAL BALTIMORE, MD
(1986-1992)
EXECUTIVE VICE PRESIDENT

SINAI HEALTH SERVICES
(1986-1992)
VICE PRESIDENT
(1984-1986)
Responsible for the day-to-day operation of this 467-bed teaching hospital and medical center. Affiliated with the Johns Hopkins Medical School and with an operating budget exceeding $190 million and 2,700 FTEs. All aspects of this organization reported to the COO with the exception of Finance. Advised the President on operational and strategic policy. Member of Medical Staff and Board Executive Committees. Served as Chief Operating Officer of holding company, which had responsibility for all hospital-affiliated corporations. Acted as CEO during absence of President.

ASSISTANT ADMINISTRATOR
GREATER LAUREL BELTSVILLE HOSPITAL
LAUREL, MD
(1981-1984)
Assistant Administrator of 236-bed acute-care facility which was part of a 900-bed multi-unit system.

ASSISTANT ADMINISTRATOR
WAYNESBORO HOSPITAL
WAYNESBORO, PA.
(1979-1981)
Acting CEO from 1979 to 1980 while recruiting permanent CEO. Responsible for managing all operations of the hospital

ADMINISTRATIVE FELLOW – 4/79-12/79
ADMINISTRATIVE RESIDENT – 8/78-7/79
EVENING ADMINISTRATOR – 7/77-8/78
RICHMOND MEMORIAL HOSPITAL
RICHMOND, VA.

CHRISTOPHER M. DADLEZ, FACHE

EDUCATION

Loyola College, Baltimore, MD
Advanced Graduate Course in Business and Finance
Medical College of Virginia, Virginia Commonwealth University
Richmond, VA Masters in Hospital Administration 1979
University of New Hampshire, Durham NH
Bachelor of Arts, Biology 1975

MEMBERSHIPS & APPOINTMENTS

Alliance of Independent Academic Medical Centers (AIAMC)
Board of Directors and Executive Committee – 2005 to present
American College of Healthcare Executives (ACHE) – Fellow – 1990 to present
American Hospital Association Regional Policy Board – Alternate Delegate and Delegate – 2007 to present
American Hospital Association Equity of Care Committee – 2011
American Hospital Association Fellow in Healthcare Reform - 2011
Association of American Medical Colleges (AAMC) – Member – 1984 to present
Business Hall of Fame – 2011
Council of Teaching Hospitals and Health Systems (COTH) – Member – 1984 to present
Council for Accreditation of Health Management Education – Surveyor – 2006 to present
Catholic Health Association (CHA) – Member – 2000 to present
Connecticut Hospital Association – Board of Directors – 2006 to present
Chairman, Board of Directors – 2010 to present
Vice Chairman, Board of Directors – 2008 to 2010
Chairman, Finance Committee – 2006 to present
Capital Area Health Consortium – Member – 2004 to present
Connecticut Catholic Hospital Council – Member – 2004 to present
Connecticut Catholic Conference – Member – 2004 to present
Governor's Task Force on Hospital Reform – Member – June to December 2007
Governor's Connecticut Healthcare Reform Advisory Board – 2009-2010
Medical College of Virginia, Department of Healthcare Administration
Alumni Executive Committee and Past President
Adjunct Faculty/Lecturer/Preceptor

Ohio Hospital Association
Research & Education Foundation Board of Directors 2001 to 2003
Committee on Workforce Crisis Board of Directors 2001 to 2003
Akron Regional Hospital Assoc. Board of Directors 2003
University Hospitals Regional Network Board of Directors 2000 to 2003
Premier Health Alliance – Chicago, IL – Board of Trustees and various committees (1993 to 1996)
New Jersey Hospital Association (1993 to 2000)
NJHA – Treasurer
NJHA – Chairman, Finance Committee
NJHA – Investment Committee
NJHA – Chairman of the Political Action Committee
NJHA – Member of the Board of Trustees/Executive Committee
NJHA – Member of Health, Research and Educational Trust of New Jersey – Board of Directors
NJHA – Member for Center for Health Affairs Board
NJHA – Past Chairman, Integrated Delivery System Committee
NJHA – Past Chairman, Committee on Managed Care
NJHA – Member of Visioning and Strategic Planning Committee
NJHA – Member of Select Committee for Development of New Payment System
NJHA – Member of Membership Committee
NJHA – Member of Executive Compensation Committee
New Jersey Joint Teaching Hospital Forum
First Option Health Plan of New Jersey, Founder/Board of Trustees/Executive Committee
Council of Teaching Hospitals – Delegate to American Association of Medical Colleges

CHRISTOPHER M. DADLEZ, FACHE

American Hospital Association – Political Action Delegate
Johns Hopkins University, Department of Healthcare Administration
Adjunct Faculty/Lecturer/Preceptor

ITEMS OF NOTE

Served as faculty member and speaker at many national healthcare conferences and have appeared on television and radio programs to discuss all aspects of the healthcare field. In 1992 received the CAPE award for the finest healthcare program aired on cable television in New Jersey.

CONNECTICUT COMMUNITY SERVICE

Governor's Council on Economic Competitiveness and Technology	Member	2006 to present
MetroHartford Alliance	Board of Directors	
Diversity and Inclusion Committee	Chairman	2005 to present
Malta House of Care	Board of Directors	2006 to present
Mayor's Healthy Communities Initiative	Member	2005 to present
Committee to End Chronic Homelessness	Member	2005 to 2006
Greater Hartford Arts Council	Member	2006 to present
Bushnell Ovations Committee	Member	2005 to 2006

OHIO COMMUNITY SERVICE

United Way	Board of Directors	2001 to 2004
Catholic Charities	Board of Directors	2001 to 2004
Walsh University	Board of Directors	2001 to 2004
Boy Scouts of America	Board of Directors	2001 to 2004
Canton Central Catholic High School	Board of Directors	2001 to 2004
YMCA	Board of Directors	2001 to 2004
Stark County Development Board	Board of Directors	2001 to 2004

PRIOR COMMUNITY SERVICE

Asbury Park Soup Kitchen
American Cancer Society
American Heart Association – 1995 Service Award
Catholic Charities
Founder and Chairman, Long Branch Tomorrow
Ronald McDonald House – Board of Trustees
Monmouth Chemical Dependency Center – Board of Trustees
Long Branch Chamber of Commerce – Board of Directors
Children's Psychiatric Center
Girl Scouts – Monmouth Council
Juvenile Diabetes Foundation – Chaired 1996 "Walk for the Cure"
Honored as Long Branch "Man of the Year 1994"
March of Dimes – Chaired "Walk America"
Monmouth University
United Cerebral Palsy – 1995 Service Award
Honored in 1996 by the Urban League with the Founder's Award

PERSONAL

Born June 16, 1953
Married 34 years to Eileen
Children: Nina age 26 Greg age 24

HOBBIES

Tennis, running, soccer, reading, French

Curriculum Vitae

Name	John F. Rodis, M.D.
Date of Birth	December 27, 1955
Place of Birth	Brooklyn, New York
Home Address	46 Dorset Lane Farmington, Connecticut 06032-2330
Office Address	Saint Francis Hospital and Medical Center Department of Obstetrics and Gynecology 114 Woodland Street Hartford, Connecticut 06105
Telephone	Office: (860) 714-4457 Home: (860) 678-1218
Martial status	Marytherese Conway - October 2, 1987
Children	Alexandra - September 8, 1989 Katrina - May 7, 1992 Anna - May 22, 1995

Education

1972-1976	BA- Biology Cornell University Ithaca, New York
1976-1980	MD Autonomous University of Guadalajara Guadalajara, Mexico
1980-1981	Fifth Pathway St. Joseph's Hospital & Medical Center Paterson, New Jersey
1981-1985	Resident, Obstetrics and Gynecology St. Joseph's Hospital & Medical Center Paterson, New Jersey
1985-1987	Fellowship in Maternal-Fetal Medicine University of Connecticut Health Center Farmington, Connecticut

	1993-1996	Fellowship in Human Genetics Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
	2005	Six Sigma Green Belt Certification
	2007	American College of Physician Executives PIM Course
Licensure	New Jersey Connecticut New York	40792 26709 158721
Boards	1989	Board Certified, American Board of Obstetrics and Gynecology
	1990	Sub-Specialty Certification, Certified by the Division of Maternal-Fetal Medicine, American Board of Obstetrics and Gynecology
	1998	Passed Recertification Examination in Obstetrics and Gynecology and Maternal-Fetal Medicine
Appointments	1985-1987	Instructor, Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
	1987-1993	Assistant Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
	1987-1995	Assistant Professor, Department of Pediatrics School of Medicine, University of Connecticut Health Center Farmington, Connecticut
	1987 - 2001	Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine St. Francis Hospital & Medical Center Hartford, Connecticut

1987 - 2001	Associate Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine New Britain General Hospital New Britain, Connecticut
1991-1993	Residency Coordinator Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Residency Program Director Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Associate Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
1995 – 6/01	Associate Professor, Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
1/99 – 6/01	Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
7/01-3/04	Chairman, Obstetrics and Gynecology Stamford Hospital Stamford, Connecticut
9/01-5/13	Professor of Clinical Obstetrics and Gynecology Columbia University College of Physicians and Surgeons New York, New York
7/11-present	Chair, Department of Obstetrics and Gynecology Director, Women & Children's Health Services Saint Francis Hospital and Medical Center Hartford, Connecticut

2/13-Present	Saint Francis Faculty Fellow Saint Francis Hospital Education Council Hartford, Connecticut
5/13-present	Professor, Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut

Awards

1993	APGO Excellence in Teaching Award, sponsored by APGO Medical Education Foundation
1998	CREOG National Faculty Teaching Award, sponsored by CREOG
2001	CREOG National Faculty Teaching Award, sponsored by CREOG

Societies

Fellow, American College of Obstetrics and Gynecology
Member, Society for Maternal-Fetal Medicine
Connecticut Perinatal Association
Member, American Institution of Ultrasound in Medicine
International Society of Perinatal Obstetricians
Associate Member, Society of Gynecologic Investigation
New England Perinatal Society - Secretary - 1996-1997
New England Perinatal Society - Vice President 1997-1998
New England Perinatal Society - President 1998-1999
Association of Professors in Gynecology and Obstetrics
Hartford County Medical Association
Connecticut State Medical Society
American College of Physician Executives

Committee Appointments

John Dempsey Hospital/University of Connecticut School of Medicine

1986-88	Transfusion Committee
1987-90	John Dempsey Hospital Quality Assurance/Peer Review Committee
1987-90	Chairman, Obstetrics and Gynecology Quality Assurance/Peer Review
1990-2001	Transfusion Committee
1996-2001	Clinical Practice Subcommittee of the Clinical Governance Committee
1996	Clinical Research Task Force
1995-2001	Committee for Graduate Medical Education
1997-2001	Chairman, Operations Subcommittee of Committee for Graduate Medical Education
1998	Search Committee for OB/GYN Chair
1990-2001	Chairman, CADCARS Review Committee Others
1999-2001	Chairman, Committee on Graduate Medical Education
2002-2004	At-large Member, Medical Board

Stamford Hospital Committees/Positions

2002-2004	Chair, Department of Obstetrics and Gynecology
7/01/03- 2011	Senior Vice President Medical Affairs, Chief Medical Officer
2001-2003	Blood Bank Committee
2001-2011	Patient Safety Committee
2001-2011	OR Committee
2002-2011	Credentials Committee
2003-2011	Strategy and Market Development Committee (Board Committee)
2003-2011	Medical Executive Committee
2003-2011	Bylaws Committee
2003-2011	Clinical Leadership Council
2003-2011	Quality and Clinical Affairs Committee (Board Committee)
2003-2011	Ops Council
2003	Chair- Credentials Task Force
2003	Chair, Ob/Gyn Chair Search Committee
2004	Chair, Surgery Chair Search Committee
2004	Emergency Department Chair Search Committee
2002-2004	Medical Board
2005	Chair, Pathology Chair Search Committee
2006	Co-Chair, Radiology Chair Search Committee

Saint Francis Hospital and Medical Center Committees/Positions

2011–present	Chair, Department of Obstetrics and Gynecology
2011-present	Director, Women & Infants Health Services
2011-present	Co-chair, Women & Infants Quality and Practice Council
2011-present	Medical Staff Quality Committee
2011-present	St. Francis Medical Group Board of Directors
2011-present	Chiefs' Forum
2011-present	Capitol Budget Committee
2011-present	IT Executive Steering Committee
2011–present	Surgical Service Performance Improvement Committee
2011-present	OR Steering Committee
2012-present	Quality & Patient Safety

Others (State and National Ob/Gyn Educational Organizations)

1989-1995	Connecticut Hospital Association Committee on Quality Assessment, Chairman, Panel on Obstetrics
1995-2011	Committee on Quality Assessment, Connecticut Hospital Association
1998 -2001	Alternate Program Director Representative for Region I - Council on Resident Education in Obstetrics & Gynecology
1999-present	American Board of Obstetrics and Gynecology Oral Board Examiner
2009-2011	Chair, Chief Medical Officer Group, New York-Presbyterian Healthcare System

Editorial consultation	American Journal of Obstetrics and Gynecology Obstetrics and Gynecology Journal of Clinical Ultrasound American Journal of Perinatology Journal of Maternal-Fetal Medicine Connecticut Medicine- Associate Editor

Grants/Clinical Trials:
NIH grant 1991, "Study of CF carrier screening in primary care settings", Robert M. Greenstein (Principal investigator), John F. Rodis, MD, (Co-Principal Investigator)

CT Research Foundation 1988, "Role of Chlamydia and mycoplasma in villus sampling", John F. Rodis, MD, (Principal investigator)

Adolor Corporation Protocol 14CL306: A Multicenter Phase III, Double-Blind, Placebo-Controlled, Study of ADL8-2698 in Opioid-Induced Postoperative Bowel dysfunction/Postoperative Ileus in Subjects Undergoing Total Abdominal hysterectomy (Principal Investigator)

Publications

1. Cusick W, Leuci D, Viscarello RR, Rodis JF. Anaphylactoid syndrome of pregnancy after intracervical dinoprostone for cervical ripening: a report of 3 cases. J Reprod Med 50:225-228, 2005

2. Cusick W, Provenzano J, Sullivan CA, Gallousis FM, Rodis JF. Fetal nasal bone length in euploid and aneuploid fetuses between 11 and 20 weeks' gestation: a prospective study. J Ultrasound Med 23:1327-1333, 2004

3. Feldman DM, Borgida AF, Rodis JF, Leo MV, Campbell. A randomized comparison of two regimens of misoprostol for second-trimester pregnancy termination. Am J Obstet Gynecol 189:710-713, 2003

4. Cusick W, Stewart J, Parry M, McLoed G, Rakos G, Sullivan C, Rodis J. State mandated prenatal human immunodeficiency virus screening at a large community hospital. Conn Med 67:7-10, 2003

5. Egan JF, Rodis JF, Benn PA. Ultrasound markers of Fetal Down Syndrome. JAMA 285:2856-2857, 2001

6. Feldman DM, Borgida AF, Trymbulak WP, Sanders MM, Barsoom MJ, Rodis JF. Clinical implications of velementous cord insertion in triplet gestations. Am J Obstet Gynecol 184:809-811, 2002

7. Benn PA, Gainey A, Ingardia CJ, Rodis JF, Egan JFX. Second trimester maternal serum analytes in triploid pregnancies: correlation with phenotype and sex chromosome complement. Prenatal Genetics 21:680-686, 2001

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX. Outcomes of pregnancies complicated by ruptured membranes after genetic amniocentesis. Am J Obstet Gynecol 183:937-939, 2000

9. Feldman DM, Borgida AF, Rodis JF, Campbell WA: Irreversible maternal brain injury during pregnancy: a case report and review of the literature. Obstet Gynecol Survey 55:708-714, 2000

10. Barsoom MJ, Prabulos AM, Rodis JF, Turner GW: Vanishing gastroschisis and short bowel syndrome. Obstet Gynecol 96:818-819, 2000

11. Ling PY, Leo MV, Turner G, Rodis JF, Campbell WA. Amnioreduction in triplet fetofetal transfusion. Obstet Gynecol 96:843, 2000

12. Egan JFX, Benn, PA, Borgida AF, Rodis, JF, Campbell WA, Vintzileos AM: Efficacy of screening for fetal Down syndrome in the U.S. from 1974 to 1997. Obstet Gynecol 96:979-985, 2000

13. Benn PA, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. J Matern Fetal Med 9:165-169, 2000

14. Benn PA, Rodis JF, Beazoglou T. Cost-effectiveness of estimating gestational age by ultrasound in Down syndrome. Obstet Gynecol 94:29-33, 1999

15. Benn PA, Leo MV, Rodis JF, Beazoglou T, Collin R, Horne D. Maternal serum screening for fetal trisomy 18: a comparison of fixed cut-off patient specific risk protocols. Obstet Gynecol 93:707-711, 1999

16. Rodis JF. Parvovirus infection. Clin Obstet Gynecol 42:107-120, 1999

17. Rodis JF, Arky L, Egan JFX, Borgida AF, Leo, MV, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Am J Obstet Gynecol 181:1128-1132, 1999

18. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus nonrotational forceps: maternal and neonatal outcomes. Am J Obstet Gynecol 181:1185-1187, 1999

19. Odibo AO, Rodis JF, Sanders M, Borgida AF, Wilson M, Campbell WA. The relationship of amniotic fluid markers of intraamniotic infection with histopathology in cases of preterm labor. J Perinatol 19:407-412, 1999

20. Leo MV, Odibo A, Ling PY, Rodis JF, Borgida A, Campbell W. Transverse arrest: a review of outcomes of rotational forceps and cesarean delivery at a single center. Prim. Care Update Ob Gyns. 5:186, 1998

21. Smulian JC, Egan JF, Rodis JF. Fetal hydrops in the first trimester associated with maternal parvovirus infection. J Clin Ultrasound 26:314-316,1998

22. Odibo AO, Campbell WA, Feldman D, Leo MV, Borgida AF, Rodis JF: Resolution of human parvovirus-induced hydrops after intrauterine transfusion. J Ultrasound Med 17:547-550,1998

23. Feldman DM, Odibo AO, Campbell WA, Rodis JF: Iatrogenic monoamniotic twins as a complication of therapeutic amniocentesis. Obstet Gynecol 91:815-816, 1998

24. Rodis JF, Borgida AF, Wilson M, Egan JFX, Leo MV, Odibo AO, Campbell WA. Management of parvovirus infection in pregnancy and outcomes of hydrops: A survey of the Society of Perinatal Obstetricians members. Am J Obstet Gynecol 179:985-988,1998

25. Rodis JF, Rodner C, Hansen A, Borgida A, Spivey G, Rosengren S. Long-term outcome of children following maternal human B19 parvovirus infection. Obstet Gynecol 91:125-128, 1998

26. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation between umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1. J Matern Fetal Med 6:67-70, 1997

27. Oncken CA, Hardardottir H, Hatsukami DK, Lupo VR, Rodis JF, and Smeltzer JS. Effects of transdermal nicotine or smoking on nicotine concentrations and maternal-fetal hemodynamics. Obstet Gynecol 90:569-574, 1997

28. Odibo, AO, Turner GW, Borgida AF, Rodis JF, Campbell WA: Late prenatal ultrasound features of hydrometrocolpos secondary to cloacal anomaly: case reports and review of the literature. Ultrasound Obstet Gynecol. 9:419-421, 1997

29. Benn PA, Borgida AF, Horne D, Briganti S, Collins R, Rodis JF. Down syndrome and neural tube defect screening: The value of using gestational age by ultrasonography. Am J Obstet Gynecol 176:1056-1061, 1997

30. Gottschall D, Borgida AF, Mihalek JJ, Sauer F, Rodis JF. A randomized clinical trial comparing prostaglandin E2 gel for preinduction cervical ripening. Am J Obstet Gynecol 177:1067-1070, 1997

31. Prabulos AM, Chen H, Rodis JF, Ruby S, Campbell WA. Angiographic embolization of a ruptured renal artery aneurysm during pregnancy. Obstet Gynecol 90:663-665, 1997

32. Rodis JF, McIlveen P, Egan JFX, Borgida AF, Turner GW, Campbell WA. Monoamniotic twins: improved perinatal survival with accurate prenatal diagnosis and antenatal fetal surveillance. Am J Obstet Gynecol 177:1046-1049, 1997

33. Smulian JC, Vintzileos AM, Rodis JF, Campbell WA: Community-based obstetrical ultrasound reports - documentation of compliance with suggested minimum standards. J Clin Ultrasound 24:123-127, 1996

34. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for trisomy 21 in the second trimester fetuses. Obstet Gynecol 89:734-737, 1997

35. Smulian JC, Bhandari, V, Campbell WA, Rodis JF, Vintzileos AM: Value of umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1 as predictors of neonatal hematologic indices and suspected early sepsis. J Matern Fetal Med. 6:254-259, 1997

36. Vintzileos AM, Campbell WA, Rodis JF, Guzman ER, Smulian JC, Knuppel, RA: The use of second trimester genetic sonogram in guiding clinical management of patients at increased risk for fetal trisomy 21. Obstet Gynecol 87:948-952, 1996

37. Vintzileos AM, Egan JFX, Smulian JC, Campbell WA, Guzman ER, Rodis JF: Adjusting the risk for trisomy 21 by a simple ultrasound method using fetal long bone biometry. Obstet Gynecol 87:953-958, 1996

38. Lefcourt LA, Rodis JF: Obstructive sleep apnea in pregnancy. Obstet Gynecol Surv 51:503-506, 1996

39. Benn PA, Horne D, Briganti S, Rodis JF: Elevated second trimester maternal serum hCG alone or in combination with elevated alpha fetoprotein. Obstet Gynecol 87:217-222, 1996

40. Bork MD, Smeltzer JS, Egan JFX, Rodis JF, DiMario FJ, Campbell WA: Prenatal diagnosis of intracranial lipoma associated with agenesis of the corpus callosum. Obstet Gynecol 87:845-848, 1996

41. Hardardottir H, Kelly K, Bork MD, Cusick W, Campbell WA, Rodis JF: Atypical presentation of preeclampsia in high-order multifetal gestations. Obstet Gynecol 87:370-374, 1996

42. Cusick W, Rodis JF, Vintzileos AM, Albini SM, McMahon M, Campbell WA: Predicting pregnancy outcome from the degree of maternal serum alpha fetoprotein elevation. J Reprod Med 41:327-332, 1996

43. Cusick W, Bork MD, Fabbri EL, Benn P, Rodis JF, Buttino L Jr: Trisomy 16 fetus surviving into the second trimester. Prenatal Diag 15:1078-1081, 1995

44. Smulian JC, Campbell WA, Rodis JF, Feeney L, Fabbri EL, Vintzileos AM: Gender-specific second- trimester biometry. Am J Obstet Gynecol 173:1195-1201, 1995

45. Cusick W, Salafia CM, Ernst L, Rodis JF, Campbell WA, Vintzileos AM: Low dose aspirin therapy and placental pathology in women with poor prior pregnancy outcomes. Am J Reprod Immunol 34:141-147, 1995

46. Smulian J, Vintzileos AM, Ciarleglio L, Rodis JF, Campbell WA: Gender-specific patterns of second trimester femur and humerus measurements in fetuses with Down Syndrome. J Mat Fetal Med 4:225-230, 1995

47. Borgida AF, Rodis JF, Hanlon W, Craffey A, Ciarleglio L, Campbell WA: Second- trimester abortion by intramuscular 15-methyl-prostaglandin F_{2alpha} or intravaginal prostaglandin E_2 suppositories: A randomized trial. Obstet Gynecol 85:697-700, 1995

48. Cusick W, Bork MD, Bourque MD, Egan JFX, Rodis JF, Campbell WA: Congenital (Paraesophageal) Hiatal Hernia. The Fetus 4(3):1-5, 1994

49. Smulian JC, Rodis JF, Campbell WA, Grant-Kels JM, Vintzileos AM: Non-oral pyogenic granuloma in pregnancy: a report of two cases. Obstet Gynecol 84:672-674, 1994

50. Campbell WA, Vintzileos AM, Rodis JF, Ciarleglio L, Craffrey A: Efficacy of the biparietal diameter/femur length ratio detect Down syndrome in patients with an abnormal biochemical screen. Fetal Diagn Ther 9:175-182, 1994

51. Cusick W, Vintzileos AM, Rodis JF: The use of second trimester fetal growth curves in predicting intrauterine growth retardation in cases of unexplained maternal serum alpha fetoprotein elevations. J Mat Fetal Med 3:203-207, 1994

52. Lettieri L, Rodis JF, McLean DA, Campbell WA, Vintzileos AM: Incarceration of the gravid uterus. Obstet Gynecol Survey 49:642-646, 1994

53. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. Am J Obstet Gynecol 170:1131-5, 1994

54. Vintzileos AM, Lettieri L , Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. J Mat Fetal Med 3:64-68, 1994

55. Campbell WA, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, Nardi DA: Use of the transverse cerebellar/abdominal circumference ratio in pregnancies at risk for intrauterine growth retardation. J Clin Ultrasound 22:497-502, 1994

56. Egan JFX, Petrikovsky BM, Vintzileos AM, Rodis JF, Campbell WA: Combined pentalogy of Cantrell and sirenomelia - a common etiology? Am J Perinatol 10(4):327-329, 1993

57. Smulian JC, Bandari V, Rodis JF, Egan JFX, Bosse KK, Campbell WA, Vintzileos AM: Fetal inferior vena cava thrombosis: A case report. The Fetus 3(6):7-11, 1993

58. Smulian JC, Rodis JF, Campbell WA, Vintzileos AM: Antenatal diagnosis of severe penile hypospadias. The Fetus 3(4)5-10, 1993

59. Lettieri, L, Vintzileos AM, Rodis JF, Albini SM, Salafia CM: Does "idiopathic" preterm labor resulting in preterm birth exist? Am J Obstet Gynecol 168;1480-1485, 1993

60. Campbell WA, Yamase HT, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique development. Fetal Diagn Ther 8:135-143, 1993

61. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Salafia CM, Pezzullo JC: Do survival and morbidity of the very low birthweight infant vary according to the primary pregnancy complication resulting in preterm delivery? Am J Obstet Gynecol 169:1233-1239, 1993

62. Lettieri L, Rodis JF, Vintzileos AM, Feeney L, Ciagleglio L, Craffey A: Ear length in second trimester aneuploid fetuses. Obstet Gynecol 81:57-60, 1993

63. Benn P, Ciarleglio L, Lettieri L, Rodis J, Greenstein R: A rapid (but wrong) prenatal diagnosis (letter). N Engl J Med 326:1638-40,1992

64. Lettieri L, Vintzileos AM, Rodis JF, Egan JFX, Wolf EJ, McLean DA: Transverse cerebellar diameter measurements in twin pregnancies and the effect of intrauterine growth retardation. Am J Obstet Gynecol 167:982-5, 1992

65. Wolf EJ, Vintzileos AM, Rosenkrantz TS, Rodis JF, Lettieri L, Mallozzi A: A comparison of pre-discharge survival and morbidity in singleton and twin very low birth weight infants. Obstet Gynecol 80:436-9, 1992

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Non-peer Reviewed Publications

1. Rodis JF: Spring is parvovirus time: how to counsel your patients. Ask the Perinatologist. Sarasota Memorial Hospital, Spring 1994.

2. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical and umbilical cord gases. Am J Obstet Gynecol 166:1589, 1992 (Reply to the Editor).

3. Rodis JF, Vintzileos AM: Scanning to diagnose congenital anomalies. Contemp Obstet Gynecol 36:45-54, 1991

4. Rodis JF: Lyme disease in pregnancy. The Unicorn Perinatal Newsletter, 1991, Vol. 1, No. 1.

5. Rodis JF, Vintzileos AM: A sound way to diagnose congenital anomalies. Contemp Obstet Gynecol 36:65-76, 1991

6. Rodis JF, Quinn DL, Garry W, Anderson LJ, Rosengren SS, Cartter M, Campbell WA, Vintzileos AM: Management and outcomes of pregnancies complicated by human B19 parvovirus infection. Clinical Digest Series 2:5-6, 1991.

7. Rodis JF, Vintzileos AM: Congenital heart defects-and other prenatal findings. Contemp Pediatr 8:58-78, 1991

8. Rodis JF, Vintzileos AM: Prenatal diagnosis by ultrasound. Contemp Pediatr 8:77-94, 1991

9. Nochimson DJ, Vintzileos AM, Campbell WA, Rodis JF, Montgomery JT: "Guidelines for Obstetrical Care". The University of Connecticut Health Center, March 1988.

Chapters

1. Rodis JF: Parvovirus Infection. In: Clinical Obstetrics and Gynecology; Roy M. Pitkin, M.D. and James R. Scott, M.D., Eds., Lippincott Williams & Wilkins, Inc., Philadelphia, PA., pp 107-112. 1999

2. Rodis JF: Intraauterine Fetal Demise. In: Fetal Disorders; Editor Boris Petrikovsky, M.D., Ph.D., Wiley and Sons, New York, New York, pp 185-192, 1998

3. Rodis JF: Fetal Infections. In: Fetal Disorders.; Editor Boris Petrikovsky, M.D., Ph.D., Wiley and Sons, New York, New York, pp 249-285, 1998

4. Rodis JF. Multiple Gestation. In: The Physiologic Basis of Gynecologic and Obstetrics, 1st edition, Eds. Seifer, Samuels, Kniss, Williams & Wilkins, Baltimore, MD, 1998

5. Borgida AF, Rodis JF. Twin Pregnancy. In: Quilligan EJ, Zuspan FR, Eds., Current Therapy In Obstetrics and Gynecology 5th Edition. W.B. Saunders, Philadelphia, PA., pp 364-368, 1999

6. Rodis JF: Parvovirus infection in pregnancy. In: Current Obstetric Medicine, Volume 3. Editors Lee, Garner, Barron, Coustan, Mosby-Year Book, Inc., St. Louis. pp159-181, 1995

7. Rodis JF, Vintzileos AM: Parvovirus. In: Viral Diseases in Pregnancy. Ed: Gonik B. Springer-Verlag NewYork, Inc., 1994, 196-214.

8. Vintzileos AM, Campbell WA, Rodis JF: Antepartum fetal assessment by ultrasonography: The fetal biophysical profile. In: Ultrasonography in Obstetrics and Gynecology, Third Edition, Ed. Callen PW, WB Saunders, Philadelphia, 1994, pp 487-502.

9. Vintzileos AM, Campbell WA, Rodis JF: Antepartum surveillance in patients with preterm premature rupture of the membranes, In: Eds. Pitkin RM, Duff P, Clinical Obstet Gynecol, 1991, pp 779-793

10. Vintzileos AM, Campbell WA, Rodis JF: Tests of fetal well being in premature rupture of the membranes, In: Obstet Gynecol Clin North Am, Eds. Weiner CP, Wenstrom KD, WB Saunders, 19:2:281-307, 1992

11. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Clinical Maternal-Fetal Medicine. Editors Winn HN, Hobbins JC, The Parthenon Publishing Group, New York, 2000.

12. Vintzileos AM, Campbell WA, Rodis JF: Percutaneous intrauterine fetal shunting, In: Textbook of Operative Obstetrics. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 110-113

13. Rodis JF, Vintzileos AM: Intrauterine Fetal Death. In: Operative Obstetrics, Second Edition. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 192-203

14. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Antepartum Fetal Assessment. Editor A. Antsaklis (Greece) (In press)

15. Vintzileos AM, Rodis JF: Growth discordancy in twins. In: Abnormal Fetal Growth, Ed. Divon MY, Elsevier Science Publishing Co., New York, 1991, pp 289-317.

16. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile scoring: current status. In: Clinics in Perinatology, Ed. Manning FA, W.B. Saunders Company, 1989 pp 661-689.

17. Campbell WA, Vintzileos AM, Rodis JF, Bors-Koefoed R, Nochimson DJ: The use of beta-blocking agents to treat hypertension during pregnancy. In: Perinatal Pharmacology, Ed. Petrie RH, Oradell, New Jersey, Medical Economics Co. Inc., 1989, pp 151-162.

Invited Regional and National Lectures:

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". New Orleans, LA May, 1998

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". Philadelphia, PA May,1999

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". San Francisco,CA May, 2000

Invited lecturer for the "71st Annual Meeting of the New England Obstetrical & Gynecological Society, Topic – " Shoulder Dystocia", October 20, 1999

Invited lecturer for the "14th Annual: A Day with the Perinatologists – Perspectives in Practice", Sponsored by Creighton University School of Medicine, Omaha, Nebraska. October 22-23, 1999

Invited Lecturer for Ultrasound Symposium, St. Francis Hospital and Medical Center, Topic: Role of Ultrasound Multiple Gestations. Farmington, CT April 8, 2000

Invited Lecturer for the New Jersey Maternal Fetal Medicine Society, New Brunswick, NJ. Topic: Parvovirus Infection in Pregnancy. December 2000

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – Fetal Death: Diagnosis, Evaluation and Management. Chicago, IL May, 2001

Invited Lecturer at the 27th Annual Sanford Cole MD Memorial OBGYN Symposium, Miami, Florida. Late Preterm & Early Term Births: Reducing Elective Deliveries before 39 Weeks. January 25, 2013.

Abstracts

1. Feldman DM, Trymbulak W, Sanders MM, Rodis JF, Borgida AF: Clinical implications of velamentous cord insertion in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

2. Egan JFX, Rodis JF, Feldman DM, Barsoom M, DeRoche M, Borgida AF: Does the Kessler Index reflect trends of Down syndrome livebirths in the U.S.? Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

3. Borgida AF, Dixon A, Feldman DM, Rodis JF, Egan, JFX: Recurrence rate of preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

4. Rodis JF, Feldman DM, Barsoom, M, Herndon A, McKenna P: Antenatal hydronephrosis is a sign of neonatal vesicoureteral reflux. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

5. Rodis JF, Feldman DM, Arky L, Campbell WA, Borgida AF: Normal values of laboratory Tests used in the evaluation of preeclampsia in triplet gestations. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

6. Rodis JF, Feldman DM, Arky L, Campbell WA , Borgida AF: Laboratory evaluation for preeclampsia in triplet pregnancies. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

7. Ling PY, Kong E, Borgida AF, Rodis JF, Egan JFX: Outcome of fetuses with echogenic bowel detected by second trimester ultrasound in a non-referral population. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX : Outcome of pregnancies complicated by ruptured membranes after genetic amniocentesis. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

9. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX: Outcome of pregnancies complicated by second trimester preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

10. Benn P, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

11. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Discordance in sonographically determined estimated fetal weights and birth weights in triplet pregnancies across gestational age.

Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

12. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

13. Benn P, Leo MV, Beazoglou T, Rodis JF: Selecting an optimal strategy for second trimester trisomy 18 screening. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

14. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus Non-rotational Forceps: Maternal and Neonatal Outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

15. Leo MV, Odibo, AO, Ling, PY, Rodis JF, Borgida AF, Campbell WA; Transverse Arrest: a review of Outcomes of Rotational Forceps and Cesarean Delivery at a Single Center. ACOG National Clinical Meeting, New Orleans, LA, May 1998. (Poster presentation)

16. Klein S and Rodis JF - Devoting time to colposcopy: teaching residents what they need to know. 1998 CREOG/APGO Meeting, Orlando, FL, March 4-7, 1998 (Poster presentation)

17. Odibo AO, Campbell WA, Feldman D, Leo MV, Borgida AF, Rodis JF: Resolution of human parvovirus-induced hydrops after intrauterine transfusion. American Institute of Ultrasound in Medicine Annual Meeting, Boston, MA. March 22-25, 1998 (Oral presentation)

18. Gottschall D, Borgida AF, Feldman D, Alberti W, Rodis JF: Preinduction cervical ripening comparing 50 and 100 mcg of misoprostol. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

19. Campbell WA, Feeney L, Fabbri EL, Iannucci P, Borgida AF, Rodis JF, Clive J: Assessment of amniotic fluid index using a curvilinear transducer: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

20. Campbell WA, Sanders M, Rosenkrantz T, Leo MV, Odibo AO, Ling PY, Rodis JF: A center's nine-year outcome experience with congenital diaphragmatic hernia. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

21. Odibo AO, Rodis JF, Sanders MM, Borgida AF, Wilson M , Campbell WA: Correlation of amniotic fluid markers of intraamniotic infection with histopathology in cases of preterm labor: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7 1998. Poster presentation.

22. Odibo AO, Borgida AF, Egan JFX, Rodis JF, Sanders MM, Campbell WA: Relationship of amniotic fluid glucose with histopathologic chorioamnionitis in cases of preterm labor with intact membranes: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

23. Odibo AO, Borgida AF, Rodis JF, Sanders MM, Leo MV, Campbell WA: The relationship of gestational age to histologic chorioamnionitis in preterm labor with intact membranes. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

24. Rodis JF, Borgida AF, Wilson M, Egan JFX, Leo MV, Odibo AO, Campbell WA: Management of Parvovirus Infection in Pregnancy and Outcomes of Hydrops: A Survey of SPO Members. Society of Perinatal Obstetricians, Miami, FL, February 2-7, 1998 (Poster presentation)

25. Rodis JF, Rodner C, Hansen A, Borgida A, Spivey G, and Rosengren S. Long-term outcome of children following maternal human B19 parvovirus infection. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Oral presentation)

26. Rodis JF, McIlveen P, Egan JFX, Borgida AF, Turner GW and Campbell WA. Monoamniotic twins: improved perinatal survival with accurate prenatal diagnosis and antenatal fetal surveillance. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Poster presentation)

27. Benn PA, Borgida AF, Horne D, Briganti S, and Rodis JF. Maternal serum screening efficiency using ultrasound dating versus LMP dating. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

28. Gottschall D, Borgida AF, Mihalek JJ, Sauer F, Rodis JF. Misoprostol versus Prostin E2 gel for preinduction cervical ripening. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

29. Mihalek JJ, Borgida AF, Gotschall D, Rodis JF. Incidence of prolonged bleeding time and its association to other routine laboratory tests. American College of Obstetricians and Gynecologists, Denver CO., May 1996. (Poster presentation)

30. Karak PK, Borgida AF, Brown SL, Rodis JF, Erkmen Z, Henken ML. Polyhydramnios: a pictoral display of associated fetal structural anomalies. American Roentgen Ray Society, San Diego, May 1996. (Poster presentation)

31. Rodis JF, Rinaldi LM, Cusick W, White C: Continuity clinics in obstetrics and gynecology residency programs: one institution's experience. 1996 CREOG and APGO Annual Meeting, Albuquerque, New Mexico, March 1996. (Poster presentation)

32. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for trisomy 21 in second trimester fetuses. American Institute of Ultrasound, New York City, March, 1996. (Oral presentation)

33. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery levels of interleukin-6 (IL-6) and soluble intracellular adhesion molecule-1 (SICAM-1) with umbilical arterial blood gas measurements. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

34. Smulian JC, Bhandari V, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1 with neonatal hematologic indices and early sepsis. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

35. Smulian JC, Campbell WA, Ernst L, Vintzileos AM, Rodis JF: The relation of umbilical vein interleukin-6 and soluble intracellular adhesion molecule-1 to histologic placental inflammation. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

36. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation between umbilical artery and umbilical vein levels of interleukin-6 and soluble intracellular adhesion molecule-1. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

37. Vintzileos AM, Campbell WA, Rodis JF, Guzman ER, Smulian JC, McLean DA: The use of second trimester genetic sonogram in guiding clinical management of patients at increased risk for fetal trisomy 21. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Oral presentation)

38. Vintzileos AM, Egan JFX, Smulian JC, Campbell WA, Guzman ER, Rodis JF: Adjusting the risk for Trisomy 21 by a simple ultrasound method using fetal long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

39. Campbell WA, Vintzileos AM, Smulian JC, Rodis JF, Guzman ER, Egan JFX: Ultrasound to detect trisomy 21 using transverse cerebellar diameter and long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996.

40. Rodis JF, Rodner C, Borgida AF, Spivey G, Shulman-Rosengren S, Campbell WA. Long-term outcome of children following maternal parvovirus infection. Society of Perinatal Obstetricians, Hawaii, February, 1996.

41. Borgida AF, Eng F, Egan JFX, Rodis JF, Smeltzer JS, Turner GW, Campbell WA: Umbilical cord gas assessment in high risk twin gestations. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

42. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for Trisomy 21 in second trimester fetuses. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

43. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Gynecologic Investigation, Chicago, March, 1995.

44. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. American Institute for Ultrasound in Medicine, San Francisco, March, 1995.

45. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? New England Perinatal Society, Vermont, February, 1995. (Oral presentation)

46. Smulian JC, Feeney L, Fabbri EL, Rodis JF, Campbell WA: Second trimester sonographic prediction of fetal gender. Society of Perinatal Obstetricians, Atlanta, January, 1995.

47. Smulian JC, Campbell WA, Rodis JF, Feeney L, Fabbri EL: Gender specific second trimester biometry. Society of Perinatal Obstetricians, Atlanta, January, 1995.

48. Vintzileos AM, Campbell WA, Guzman E, Rodis JF, Rosenberg J: The use of "genetic sonogram" in fetuses at high risk for trisomy 21: Preliminary results. Society of Perinatal Obstetricians, Atlanta, January, 1995.

49. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? Society of Perinatal Obstetricians, Atlanta, January, 1995. (Poster presentation)

50. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Perinatal Obstetricians, Atlanta, January, 1995.

51. Hardardottir H, Kelly K, Bork MD, Cusick W, Rodis JF, Campbell WA: Atypical presentation of preeclampsia in high-order multifetal gestation. Society of Perinatal Obstetricians, Atlanta, January, 1995.

52. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. Society of Perinatal Obstetricians, Atlanta, January, 1995.

53. Borgida A, Rodis JF, Hanlon W, Craffey A, Ciarleglio L, Campbell WA: A prospective randomized trial comparing intramuscular 15 methyl-prostaglandin F2a to intravaginal prostaglandin E2 for second-trimester pregnancy termination. Society of Perinatal Obstetricians, Atlanta, January, 1995.

54. Rodis JF, Ciarleglio L, Egan JFX, Campbell WA, Vintzileos, AM: Women's intuition: Fact or fiction? 23rd Annual Meeting of American Society for Psychosomatic Obstetrics and Gynecology, Washington, DC, February, 1995. (Poster presentation)

55. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. American College Obstetricians and Gynecologists, Orlando, May, 1994

56. Cusick W, Ciarleglio L, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for both open neural rube defects and down syndrome. American College Obstetricians and Gynecologists, Orlando, May, 1994

57. Ciarleglio L, Cusick W, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for trisomy eighteen. Society of Perinatal Obstetricians, Las Vegas, January 1994.

58. Cusick W, Salafia C, Rodis JF, Campbell WA, Vintzileos AM: Low dose aspirin therapy and placental pathology in women with prior poor pregnancy outcomes. Society of Perinatal Obstetricians, Las Vegas, January 1994.

59. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. Society of Perinatal Obstetricians, Las Vegas, January 1994.

60. Cusick W, Ciarleglio L, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for both open neural rube defects and down syndrome. Society of Perinatal Obstetricians, Las Vegas, January 1994.

61. Smulian J, Vintzileos AM, Ciarleglio L, Rodis JF, Campbell WA: Gender-specific patterns of long-bone measurements in fetuses with trisomy 21. Society of Perinatal Obstetricians, Las Vegas, January 1994.

62. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Society of Perinatal Obstetricians, Las Vegas, January 1994.

63. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Third World on Ultrasound in Obstetrics and Gynecology, Las Vegas, October, 1993.

64. Campbell WA, Yamase HA, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique Development. International Fetal Medicine and Surgery Society, April, 1993, (Oral presentation)

65. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. American Institute of Ultrasound in Medicine, 37th Annual Convention, March, 1993.

66. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. New England Perinatal Society, February 1993. (Oral presentation-Ross Award for Best Clinical Oral Presentation and Abstract)

67. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. New England Perinatal Society, February, 1993. (Oral presentation)

68. Rodis JF, Lettieri L, McLean DA, Cusick W, Smulian J, Campbell WA, Vintzileos AM: A new method to correct the incarcerated retroflexed, retroverted gravid uterus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

69. Campbell WA, Vintzileos AM, Rodis JF, Ciarleglio L, Craffey A: Ability of biparietal diameter/femur length ratio to detect down syndrome in patients with an abnormal biochemical screen. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

70. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

71. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

72. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. Society of Perinatal Obstetricians, San Francisco, February, 1993.

73. Cusick W, Vintzileos AM, Varvarigos I, Verikios N, Tassis S, Rodis JF: Mixed umbilical cord blood gas measurements. Society of Perinatal Obstetricians, San Francisco, February, 1993.

74. Cusick W, Vintzileos AM, Rodis JF, McMahon M: The use of second trimester fetal growth curves in predicting intrauterine growth retardation in cases of unexplained maternal serum alpha fetoprotein elevations. Society of Perinatal Obstetricians, San Francisco, February, 1993.

75. Mallozzi A, Egan JFX, Attar E, Feeney L, Ciarleglio L, Rodis JF, Lettieri L, Vintzileos AM: Down Syndrome risk modification based on ultrasound. Society of Perinatal Obstetricians, San Francisco, February, 1993.

76. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained maternal serum alpha fetoprotein elevations. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

77. Lettieri L, Vintzileos AM, McLean DA, Rodis JF, Campbell WA, Wolf EJ: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Presented - Poster session)

78. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

79. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Mead J, Gray S: Does the pregnancy complication resulting in preterm delivery influence predischarge survival and morbidity? New England Perinatal Society, February, 1992. (Presented-Oral session)

80. Albini SM, Cusick W, Rodis JF, Lettieri L, McMahon M, Vintzileos AM: Routine amniocentesis is not indicated to evaluate an unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

81. Cusick W, Rodis JF, Vintzileos AM, Albini SM, McMahon M, Campbell WA: Pregnancy outcome by the degree of maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

82. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

83. Egan JFX, Vintzileos AM, Turner GT, Rodis JF, Campbell WA, Wolf EJ, Balducci J, Lettieri L, Mead J: Correlation of uterine fundal height with ultrasound in twin gestations. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

84. Rodis JF, Wolf EJ, Lettieri L, Scribner D, Campbell WA, Vintzileos AM: Management and outcome of severe preeclampsia in 209 preterm pregnancies. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992

85. Rodis JF, Vintzileos AM, Albini M, Nardi DA, Feeney L, Lettieri L, Wolf EJ, Ciarleglio L: Transverse cerebellar diameter measurements in second trimester fetuses with trisomy 21 and trisomy 18. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

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87. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Lettieri L, Mallozzi A: A comparison of predischarge survival and morbidity in singleton and twin very low birthweight infants. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

88. Campbell WA, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, Nardi DA: Use of the transverse cerebellar/abdominal circumference ratio to identify growth retarded fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

89. Campbell WA, Yamase HT, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique development. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

90. Campbell WA, Vintzileos AM, Rodis JF, Nochimson DJ: Birthweight outcome in pregnancies complicated by an elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

91. Turner GW, Vintzileos AM, Nardi DA, Feeney L, Campbell WA, Rodis JF: Neck circumference measurements in second trimester fetuses with Down syndrome. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

92. Lettieri L, Vintzileos AM, Rodis JF, Campbell WA: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

93. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session

94. Wolf EJ, Egan JFX, Rodis JF, Vintzileos AM, Miller R: Intravenous adenosine for the treatment of maternal paroxysmal supraventricular tachycardia. Armed Forces District, American College of Obstetricians and Gynecologists and Organization for Obstetric, Gynecologic and Neonatal Nurses. Cincinnati, Ohio, October 6-10, 1991.

95. Vintzileos AM, Fleming AD, Scorza WE, Wolf EJ, Balducci J, Campbell WA, Rodis JF: Relationship between fetal biophysical activities and umbilical cord blood gases. Society for Gynecologic Investigation, San Antonio, March, 1991.

96. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. New England Perinatal Society, Vermont, February, 1991.

97. Campbell WA, Cusick W, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, McLean DA: Outcome of quadruplet pregnancies using early hospitalization. New England Perinatal Society, Vermont, February, 1991.

98. Rodis JF, Vintzileos AM, Fleming AD, Ciarleglio L, Nardi DA, Feeney L, Scorza WE, Campbell WA, Ingardia C: Comparison of humerus length versus femur length in fetuses with Down syndrome. New England Perinatal Society, Vermont, February, 1991.

99. Wolf EJ, Mallozzi A, Rodis JF, Egan JFX, Vintzileos AM, Campbell WA, Lettieri L: Placenta previa is not an independent risk factor for IUGR. New England Perinatal Society, Vermont, February, 1991.

100. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm births of twins at a referral tertiary care center. New England Perinatal Society, Vermont, February, 1991.

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103. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm birth of twins at a referral tertiary care center. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

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106. Balducci J, Rodis JF, Rosengren S, Vintzileos AM, Davis G, Vosseller C: Neonatal outcome after first trimester varicella infection. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

107. Fleming AD, Salafia CM, Vintzileos AM, Rodis JF, Campbell WA, Bathan KF: The relationships among umbilical artery velocimetry, fetal biophysical profile and placental inflammation in preterm PROM. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

108. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

109. Scorza WE, Nardi DA, Vintzileos AM, Fleming AD, Rodis JF, Campbell WA: The relationship between umbilical artery Doppler velocimetry and fetal biometry. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

110. Vintzileos AM, Egan JFX, Rodis JF, Campbell WA, Wolf EJ, Balducci J: Clinical characteristics and significance of nuchal cord. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

111. Fleming AD, Rodis JF, Vintzileos AM, Ingardia C, Scorza WE, Ciarleglio L, Craffey A, Feeney L, Nardi D: Comparison of humerus length versus femur length in fetuses with Trisomy 21 and Trisomy 18. Society of Perinatal Obstetricians (SPO), San Francisco, January, 1991.

112. Vintzileos AM, Egan JFX, Campbell WA, Rodis JF, Scorza WE, Fleming AD, McLean DA: Asphyxia at birth as determined by cord blood pH measurements and correlation with neonatal outcomes. New England Perinatal Society, Vermont, February, 1990.

113. Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Egan JFX, Fleming AD, Scorza WE: The relationship between fetal biophysical assessment, umbilical artery velocimetry and fetal acidosis in patients undergoing cesarean section prior to the onset of labor. New England Perinatal Society, Vermont, February, 1990.

114. Fleming DA, Salafia C, Vintzileos AM, Rodis JF, Campbell WA, Bantham KF: The relationships among umbilical arterial velocimetry, fetal biophysical profile and placental inflammation in preterm premature rupture of the membranes. New England Perinatal Society, Vermont, February, 1990.

115. Rodis JF, Ciarleglio L, Petrikovsky BM, Egan JFX, Campbell WA, Vintzileos AM: Women's intuition: fact or fiction? Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

116. Rodis JF, Egan JFX, Craffey A, Greenstein R, Vintzileos AM: Calculated risk of chromosomal abnormalities in twin gestations. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

117. Campbell WA, Nardi DA, Vintzileos AM, Rodis JF, Egan JFX, McLean DA, Turner GW: The bicerebellar/abdomen ratio: as a gestational age independent method of assessing fetal growth. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

118. Vintzileos AM, Egan JFX, Campbell WA, Rodis JF, Scorza WE, Fleming AD, McLean DA: Asphyxia at birth as determined by cord blood pH measurements and correlation with neonatal outcomes. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

119. Fleming AD, Salafia CM, Vintzileos AM, Rodis JF, Campbell WA, Bantham KF: The relationships among umbilical arterial velocimetry, fetal biophysical profile and placental inflammation in preterm premature rupture of the membranes. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

120. Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Egan JFX, Fleming AD, Scorza WE: The relationship between fetal biophysical assessment, umbilical artery velocimetry and fetal acidosis in patients undergoing cesarean section prior to the onset of labor. Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

121. Hudgins L, Wilson-Miller K, Quinn D, Rodis JF, Cartter M, Rosengren S. Is human parvovirus B19 teratogenic: follow up on 39 infected pregnancies. Clinical Genetics, Oct 1989.

122. Vintzileos AM, Petrikovsky BM, Campbell WA, Rodis JF, Pinette MG, Egan JFX: Cord blood gases and abnormal fetal biophysical assessment in preterm premature rupture of the membranes. Society of Gynecologic Investigation (SGI), March 1989.

123. Vintzileos AM, Petrikovsky BM, Campbell WA, Rodis JF, Pinette MG, Egan JFX: Comparison of six different ultrasonic methods for predicting lethal fetal pulmonary hypoplasia. New England Perinatal Society, February, 1989.

124. Petrikovsky BM, Vintzileos AM, Nardi DA, Rodis JF, Campbell WA, Hoegsberg B: Association between elevated MSAFP and fetal obstructive uropathy changes. Society of Perinatal Obstetricians (SPO) New Orleans, February, 1989.

125. Campbell WA, Vintzileos AM, Rodis JF, Nochimson DJ, Ciarleglio L: Low maternal serum alpha fetoprotein and abnormal biparietal diameter/femur length ratio to screen for Down syndrome. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

126. Fleming AD, Salafia CM, Rodis JF, Vintzileos AM, Campbell WA: Relationship between umbilical systolic-diastolic ratio, fetal biophysical profile and histologic umbilical vasculitis. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

127. Rodis JF, Vintzileos AM, Campbell WA, Pinette MG, Nochimson DJ: Intrauterine fetal growth in discordant twin gestations. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

128. Rodis JF, Vintzileos AM, Campbell WA, Pinette MG, Nochimson DJ: Intrauterine fetal growth in concordant twin gestations. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

129. Rodis JF, Quinn DL, Garry W, Anderson LJ, Rosengren S, Vintzileos AM, Campbell WA: A large prospective study of human B19 parvovirus infection in pregnancy. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

130. Vintzileos AM, Campbell WA, Rodis JF, Nochimson DJ, Pinette MG, Petrikovsky BM: Comparison of six different ultrasonic methods for predicting pulmonary hypoplasia. Society of Perinatal Obstetricians (SPO), New Orleans, February, 1989.

131. Rosengren S, Quinn DL, Rodis JF: Fetal hydrops and congenital anomalies in association with human parvovirus infection in pregnancy. Teratology Society Meeting, 1988.

132. Rodis JF, Hovick TJ, Quinn DL, Vintzileos AM, Campbell WA, Shulman-Rosengren S, Tattersall P: Human parvovirus infection in pregnancy. New England Perinatal Society Annual Meeting, February, 1988.

133. Vintzileos AM, Campbell WA, Rodis JF, Bors-Koefoed R, Nochimson DJ: Fetal weight estimation formulas using head, abdomen, femur and thigh circumference measurements. Society of Perinatal Obstetricians (SPO), February, 1987.

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PROFESSIONAL SUMMARY

Primary Focus: long-range strategic financial planning focusing on building balance sheet strength; improving the consistency and timeliness of financial information; maximizing the System's inherent strength to improve contracting leverage, purchasing power, balance sheet reserves for program/facility development, maintaining external relationships with creditors, improving access to capital, and development of staff.

PROFESSIONAL EXPERIENCE

7/12 – present **Saint Francis Care / Saint Francis Hospital and Medical Center,** Hartford, CT

An integrated health delivery system, including 617-bed Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital, an independent rehabilitation hospital. Other system affiliates include a specialist and primary care physician group, behavioral health center, and urgent care and other access centers. The Medical Center discharges over 32,000 inpatients and treats over 500,000 outpatients annually.

SENIOR VP AND CHIEF FINANCIAL OFFICER **December 2014**

Responsible for daily financial operations, revenue cycle, supply chain, budgeting, cost accounting, and treasury functions.

SENIOR VICE PRESIDENT OF FINANCE **February 2014**

Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Successfully negotiated additional reimbursement of over $10 million over two years for the Hospital and Medical Center
- Identified and achieved cost savings of the state provider tax, resulting in additional net income to the health system of over $2 million annually
- Participate in Connecticut Hospital Association's committee on hospital finance and subcommittee on all-payor reimbursement diagnosis related group (ARP-DRG), which assisted the state's transition to modernize its reimbursement.
- Successfully negotiated a $0.5 million reduction in pharmacy overpayments
- Started the Health System's Investment Committee

VICE PRESIDENT OF FINANCE **July 2012**

Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Led the refinancing of $213 million of tax-exempt bonds into private placement debt in collaboration with seven different lending institutions
- Established service line reporting structures to educate physician and executive directors on financial and operational performance.
- Oversee the annual financial statement audit for the health system

8/07 – 7/12 **Memorial Health System,** Springfield, IL

An integrated health delivery system, including 500-bed Memorial Medical Center, Abraham Lincoln Memorial and Taylorville Memorial Hospitals, 25-bed Critical Access hospitals. Other system affiliates include home services and hospice, primary care physician group, mental health centers, urgent care centers, and property management. Annual net operating revenues were $736 million, generating a 2.6% operating margin in FY 2011(5.6% operating margin in FY 2010). The Medical Center discharges over 25,700 inpatients and treats over 490,000 outpatients annually.

DIRECTOR OF FINANCE & GENERAL ACCOUNTING

Responsible for daily financial operations, budgeting, cost accounting, charge description master, property management, treasury functions, and finance information services.

- In FY2012, collaborated with the CFO and Investment Committee to develop a $90 million new money financing plan to provide funds for two new medical office building projects; maintained A+/A1 category credit ratings by S&P and Moody's credit rating agencies.
- In FY2012, collaborated with the COO and his VP team to develop and implement monthly flexible budget to actual reporting, increasing the accountability and involvement of operational leaders in their departments' financial performance.
- Participated with the Investment Committee to review and monitor investment portfolios of over $450 million, which have outperformed the benchmark by over 27 basis points and 190 basis points for the Medical Center investments and Health System Pension investments, respectively.
- Participated in several cost savings initiative teams to reduce operating expenses, increase revenue, and develop financial reporting metrics, which led to a 2% increase in productivity (or approximately $3.2 million in salary costs) and a 20% (or $400,000) reduction in overtime.
- Led various multi-disciplinary Lean / Six Sigma teams within the supply chain, materials management, and the revenue cycle, reducing annual freight costs by over $100,000 and decreasing bad debt expense of the primary care physician group by over 50%.
- In FY 2009, collaborated with the CFO and operational leaders to complete a $150 million financing plan that issued tax-exempt bonds for use by the Medical Center and both Critical Access Hospitals; developed and implemented a credit rating strategy that secured an A+/A1 category rating from S&P and Moody's credit rating agencies.

Ernst & Young, Kansas City, MO **June 2005 – August 2007**
Manager, Assurance and Advisory Services

Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, E&Y employs over 152,000 people.

Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $100 million to over $4 billion, participated in audit committee and board of director meetings, counseled younger staff in career development, including training of new staff and seniors, managed several teams and projects simultaneously, and participated in health care tax-exempt bond issuances and other health care consulting engagements.

BKD, LLP, Kansas City, MO **July 1999 – June 2005**
Manager, Assurance and Advisory Services

BKD, LLP is a top ten CPA and advisory firm that operates 30 offices in the Midwest. BKD employs over 2,000 professionals.
Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $25 million to over $500 million, presented audit reports and management letters to finance committees and board of directors' meetings, supervised, trained, and reviewed the work of staff accountants, and mentored several staff accountants to establish career goals.

EDUCATION

Bachelor of Science, 1999, Truman State University

Master of Business Administration, 2009, Benedictine University

CERTIFICATIONS

- Certified Public Accountant Exam (passed on first attempt)
- Six Sigma Green Belt Certification
- Certified Healthcare Financial Professional

PROFESSIONAL AND CIVIC AFFILIATIONS

- President of Lincoln Land Drug Awareness Resistance Education (DARE)
  - 2007-2010
- Treasurer and Board Member of Ronald McDonald House Charity of Central Illinois
  - 2011 - 2012
- Fellow of Healthcare Financial Management Association
    - 2011 – Current
    - Treasurer, Board Member, and Sponsorship Chair of McMahon HFMA chapter
- Adjunct Accounting Faculty at the University of Illinois at Springfield
  - 2010 – 2012
- Finance Committee Member of Food Share
  - 2012 - Current

RICHARD J. GILFILLAN, MD, MBA

Professional Accomplishments

Trinity Health **November 2013 – Present**

President & Chief Executive Officer

Trinity Health is the second largest Catholic health system in the nation and fourth largest health system overall in the U.S. and operates 86 acute care hospitals, 44 home care agencies, 14 PACE centers, 70 other continuing care facilities in 20 states. Employs nearly 87,000 people including 3,300 employed physicians and 21,600 affiliated physicians. Trinity Health reported $13.6 billion in net revenues in FY2014. The ministry was formed in May 2013 with the coming together of Trinity Health and Catholic Health East. Trinity Health is sponsored by Catholic Health Ministries, a governance entity established by the Catholic Church to oversee the healing ministry and Catholic identity of Trinity Health.

Centers for Medicare and Medicaid Services **August 2010 – July 2013**

Acting Director and Director
Center for Medicare and Medicaid Innovation **September 2010 – July 2013**

Directed the development and operations of this new Center within CMS charged with identifying, testing and spreading new service delivery and payment models that reduce program expenditures while improving the quality of care for Medicare, Medicaid and CHIP beneficiaries

Accomplishments:

- Created initial strategic and operating plan and obtained first year funding
- Created effective leadership team and directed the hiring of 150 new team members
- Merged the Office of Research, Development and Information with 80 staff members into the Center
- Directed the design of key Center operational activities and processes
- Directed and participated in national campaign to introduce the Center's role and approach
- Directed the development and implementation of new CMS model initiatives including Pioneer ACOs, Comprehensive Primary Care, Bundled Payment for Care Improvement, Partnership for Patients, End Stage Renal Disease, Innovation Awards Rounds 1 and 2, State Innovation Models, and Independence at Home, that engaged over 50,000 providers caring for more than 2 million Medicare and Medicaid beneficiaries
- Participated in development of CMS ACO Shared Savings and Dual Eligibles Initiatives
- Established effective working relationships with key partners across the Administration
- Represented CMS in Congressional meetings including testifying before the Senate Finance Committee

Director

Performance-based Payment Policy Staff **August 2010 – October 2010**

Directed the staff responsible for establishing regulations for the Medicare Shared Savings Accountable Care Organization (ACO) Program, the Hospital Value Based Purchasing initiative, the Physician Value Modifier initiative, and other performance-based payment programs. After 8 weeks in this position was asked by the Administrator to assume the position of Acting Director of the Innovation Center.

Accomplishments:

- Oversaw initial development of Shared Savings ACO Regulation
- Developed proposed Quality performance measurement system for ACO Regulation
- Represented CMS in more than 30 meetings with outside parties
- Built relationships with key partners across CMS
- Developed management team and rapidly hired additional staff

Geisinger Health System, Danville Pa. **August 2005 – July2010**

Consultant, Washington DC **July 2009 – July 2010**
Geisinger Consulting Services

Provided consulting services to health care systems and payer organizations regarding the design and implementation of alternative care systems, such as Accountable Care Organizations and Patient Centered Medical Homes

Accomplishments:
- Developed an ACO model for the leading national ACO Collaborative
- Participated in marketing and recruitment campaign for ACO Collaborative that led to more than 60 participating institutions
- Designed a capabilities assessment tool that allows health systems to identify change priorities for creating ACOs
- Led a consultant team supporting client in implementing the Collaborative
- Developed strategic approach for a large health system change initiative
- Designed a series of guidebooks for health systems to use to plan transformation to accountable care
- Developed plan for a large labor union fund to significantly reduce their medical expenditures
- Provided input to Obama Administration staff and Members of Congress on healthcare reform

President & CEO Geisinger Health Plan **July 2005 – June 2009**
EVP Insurance Operations Geisinger Health System

Had P & L responsibility for the $1 Billion Insurance Operations of this Integrated Health System and participated on the Executive Leadership Team that oversaw System operations.

Accomplishments:
- Created a well integrated management team that produced outstanding results for 4 years including:
    - Growing membership by 25%
    - Significantly exceeding financial goals for four years

- Improving Quality improvement results that raised Plan's national ranking from 33rd to top 10 for 3 years.
- Helped to design ProvenCare, an innovative care redesign/bundled payment model for specialty care
- Helped to design Proven Health Navigator, an innovative care redesign and payment model for primary care
- Expanded Plan service area to double market size
- Improved the relationship between Health Plan and System Clinical Leadership to create a partnership that enabled our efforts to build innovative care and payment models
- Achieved Outstanding Accreditation from the National Committee for Quality Assurance (NCQA)

Coventry Health Care, Bethesda, MD **2001 - 2005**

Senior Vice President National Network Management

Responsible for the Network Contracting and Medical Cost Management operations for this $3 billion national managed care organization.

Accomplishments:
- Oversaw National Contracting team responsible for contracts with 5,000 hospitals and 600,000 physicians in 50 states
- Created corporate wide Medical Cost Management process that improved medical cost trend
- Developed an innovative Primary Care delivery and reimbursement model with independent physicians in three markets
- Developed new Fraud, Abuse and Claims Recovery programs

Independence Blue Cross, Philadelphia, Pa **1989 - 2000**

General Manager
AmeriHealth HMO & Insurance Company, Mount Laurel, NJ **1995 – 2000**

Profit and Loss responsibility, including start-up, for a new managed care subsidiary

Accomplishments:
- Profitably grew the business over 5 years to $300 Million Revenue base and 300,000 Commercial, Medicare and Medicaid members
- Built successful leadership team and grew staff from 15 to over 150
- Instituted quality improvement programs that led to # 1 State ranking for three years
- Oversaw the successful implementation of a new enterprise wide computer operating system.
- Directed the development of a new corporate medical informatics system

Chief Medical Officer and Senior Vice President
Independence Blue Cross and Subsidiaries, Philadelphia, PA **1992-1995**

Oversaw the medical management activities for all subsidiaries of this $3 Billion Blue Cross plan with approximately 3 million members

Accomplishments:
- Merged the medical management function of three HMO's into one 300 person staff
- Created state of the art quality, utilization and medical cost management functions
- Achieved full accreditation from the National Committee for Quality Assurance

- Developed innovative, first in the nation contact capitation program for cardiology care

Medical Director and Senior Vice President
Keystone Health Plan East **1989 – 1995**

Oversaw the medical and network management activities for this start-up HMO

Accomplishments:
- Established new Medical Management and Provider Relations Teams
- Helped directed expansion of the provider network to include 8,000 physicians and 60 hospitals
- Developed innovative Disease Management Programs
- Instituted an innovative radiology capitation program that decreased costs by 30%
- Developed one of the first in the nation commercial Resource Based Relative Value System (RBRVS) physician fee schedules that decreased costs by approximately 20%
- Achieved full NCQA accreditation

New Jersey Blue Cross and Shield **1985 – 1989**

Medical Director and Primary Care Physician
Medigroup Central HMO Trenton, NJ

Created network and medical management functions and practiced adult and pediatric primary care medicine half-time in inner city Trenton for a staff/network model HMO

Accomplishments:
- Established a new Independent Physician Association (IPA) division and management team
- Built provider network that included 15 hospitals and 500 physicians
- Led a reengineering initiative in staff primary care sites to improve waiting times
- Improved customer satisfaction in the staff model
- Established innovative mental health carve-out contract that improved care and lowered costs

Winchendon Community Health Center, Winchendon Ma **1980 – 1985**

Medical Director and Family Practitioner

Practiced full time adult, pediatric and obstetrical care and was the medical director in a small, rural poor community in Central Massachusetts.

Accomplishments:
- Built a new family medicine group practice of three physicians
- Led the conversion of a 28 bed town hospital into a Community Health Center
- Served as Secretary and Treasurer of the medical staff at parent hospital
- Established academic relationship with Medical School

Georgetown University Community Health Plan, Washington, DC **1979 – 1980**

Primary Care Family Physician

Education

The Wharton School of the University of Pennsylvania, MBA	**1992**
Hennepin County Medical Center, Family Practice Residency	**1979**
Georgetown University School of Medicine School, MD	**1976**

Georgetown University School of Foreign Service, BSFS **1971**

Board Activities:

Alliance of Community Health Plans Board of Directors **2007 – 2009**
Director on the Board of this industry Association of not-for-profit managed care organizations that includes Kaiser, Health Partners and 11 other Health Plans

Geisinger Insurance Operations Boards of Directors **2005 - 2009**
Director on the Boards of the three companies that make up Geisinger Insurance Operations

Geisinger Health Science Foundation Board of Directors **2005 – 2009**
Participated in quarterly meetings and provided updates on the performance of the Insurance Operations

New Jersey State Chamber of Commerce Board of Directors **1996 - 2000**
Director on a Board made up of CEO's and senior executives from large New Jersey companies including Prudential, Bell Atlantic, AT&T and Johnson & Johnson

AmeriHealth New Jersey Board of Directors **1995 - 2000**
Made quarterly presentations to HMO Board regarding overall strategy and results

Vice Chairman, Princeton Regional Health Commission **1992 – 1995**
Participated in and chaired monthly public meetings of the Commission overseeing public health for Princeton, NJ

Keystone Health Plan East Board of Directors **1989 – 1995**
Presented medical and quality management reports to a Board that included the IBC CEO and external directors representing large community employers

Medigroup Central Board of Directors **1985 – 1989**
Director on the Board overseeing the HMO subsidiary of New Jersey Blue Cross

Winchendon Hospital Board of Directors **1980 – 1985**
Director and member of the Hospital Executive Committee that negotiated a merger with another community hospital.

BENJAMIN R. CARTER, CPA, FHFMA

CAREER OBJECTIVE To be a CEO and Regional Leader of a large Diversified and Integrated Health Care Delivery System

EDUCATION: MBA, 1992; University of Michigan (Magna Cum Laude)
BBA, 1980; University of Michigan (Magna Cum Laude)

WORK EXPERIENCE:

May, 2013 – Present

Trinity Health; Livonia, MI
Executive Vice President and CFO/Treasurer
Responsible for the System strategic and financial operation of the 21 state Trinity Health System. Trinity Health is the second largest Catholic Health Care System in the country with total net revenues exceeding $13.5 Billion, including over 82 hospitals, 89 continuing care facilities, the largest not for profit home health agency in the country, and over 3100 employed physicians.

Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management, third party contracting and strategic payor alliances. Responsibilities also include Treasury services and asset management for $16 Billion of investable assets, debt management for $5 Billion of long term debt, investor relations, and Insurance and Risk Management Services.

Trinity is AA rated organization with a consistent record of strong operating and non-operating financial results.

March, 2010 – May, 2013

Trinity Health; Novi, MI
Senior Vice President and Chief Financial Officer
Responsible for the system financial operations of the 10 state, $9.0 Billion Trinity Health organization. Prior to merging with Catholic Health East (CHE), Trinity Health was the fourth largest Catholic Health Care system in the country, comprising 49 hospitals, 32 long term care facilities, and a 6 State home health agency. Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management and third party contracting.

Trinity Health was a AA rated organization with superior operating and non-operating performance, exceeding peer group averages.

May, 2005 – March, 2010

Detroit Medical Center; Detroit, MI

Executive Vice President and Chief Operating Officer
Responsible for the system operations of the eight hospitals and related outpatient facilities that comprise the $2 Billion Detroit Medical Center. Responsibilities include oversight of all system support services including Retail Pharmacy, Managed Care Contracting and Operations, University Laboratory and Commercial Operations, Physician Recruitment and Office Practice Management, Information Services, System wide Security, Professional Sports Medicine program, Purchasing and Procurement, and Graduate Medical Education and Centralized Credentialing.

Key accomplishments include turn around of the organization from $100 million annual loses in 2002 and 2003, to six straight years of profitability, including 2009 expected operating income of $40 million. Led key growth, cost reduction, and profit initiatives in multiple service lines contributing to successful turnaround.

1999 – May, 2005

Oakwood Healthcare, Inc.; Dearborn, MI
Chief Financial Officer and Executive Vice President
Responsible for all financial operations of the $860 million healthcare system including: Treasury Management, General Accounting (including accounts payable and payroll), budget and Decision Support, Internal Audit, Legal Services and Information Systems. As a member of the Executive Council, responsibilities include setting corporate policy and overseeing their successful implementation and maintenance. Successfully managed the implementation of a 3-year Financial Viability Plan, restoring the financial performance of the System to historically high levels. In 2004, the System achieved a total margin of $36 million, a 2.0% operating margin, and maintained an "A" rating with a stable outlook.

1997 – May 2005

Oakwood Enterprises, Inc.; Dearborn, MI
President and Executive Vice President, Oakwood Healthcare, Inc.
Responsible for the development and operation of the Oakwood Healthcare, Inc. subsidiary which operates for profit health related businesses and creates joint ventures for the system, including home services and real estate development. Have held a number of executive posts within Oakwood Healthcare, Inc., including Interim Chief Financial Officer and Interim Chief Operating Officer. Member of the Oakwood Healthcare, Inc. Executive Council, which sets policy system-wide, and is responsible for strategic planning and deployment.

1995 – April, 1997

Oakwood Healthcare System; Dearborn, MI
Senior Vice President, Support and Related Services
Responsible for Human Resources, Risk Management and Legal Affairs, Information Services, Quality Assurance, Operations Analysis, Materials Management, Architecture and Construction, and Foundations (since June, 1996) for the Corporation. Total capital and operating budgets in excess of $150 million per year. Reported directly to the Executive Vice President and Chief Operating Officer. Member of the System-wide Transition Team charged with designing the year 2000 Integrated Delivery System. Administrative Coordinator for Facilities/Planning/Technology Assessment Board Committee. Also a member of the Quality Assessment and Improvement Board and continuous Quality Improvement Steering Committee.

1991 – 1994

Oakwood United Hospitals, Inc.; Dearborn, MI
Senior Vice President and Controller
Responsible for the financial management of a five-hospital system and nursing home, with an annual budget in excess of $200 million. Responsibilities included Treasury Management, budgeting, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer. Also a member of Oakwood Health Services Operations Committee and Continuous Quality Improvement Steering Committee.

1989 – 1990

Oakwood United Hospitals, Inc.; Dearborn, MI
Vice President and Controller
Responsible for the management of the financial operations of a four-hospital system. Responsibilities included Treasury Management, budgeting, financial analysis, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer, and worked closely with the Chief Operating Officer on management issues.

1988 – 1989

Oakwood Hospital Corporation; Dearborn, MI
Vice President of Accounting and Reimbursement
Responsible for the preparation of financial statements of the Hospital and related companies. Responsibilities included management of all reimbursement functions and negotiations of third-party contracts. Also responsible for all not-for-profit and for-profit tax filings.

1986 – 1988 ***Plante & Moran CPAs; Southfield, MI***
Director of Healthcare Services, Southeastern Michigan
Responsible for the management of audit and consulting projects for the firm's healthcare clients, including hospitals, nursing homes, and home health agencies.

1980 – 1986 ***Plante & Moran CPAs; Southfield, MI***
Audit Staff and Associate
Member of the audit staff responsible for completing audits of manufacturing and municipal clients.

BOARDS: (Past examples)

- DMCIC
- DMC Care Express
- Michigan Mobile Imaging
- CareTech Solutions, Inc.
- Oakwood Assurance
- HealthLink
- Invest Michigan Advisory Board

AFFILIATIONS:

Member:

- American Institute of Certified Public Accountants
- Michigan Association of Certified Public Accountants
  - Chair, Healthcare Committee; 1993 – 1995
  - Vice Chair, Healthcare Committee; 1991 – 1993
- Healthcare Financial Management Association
  - Board Member 1989 – 1993
  - Treasurer 1993 – 1994
  - Secretary 1994 – 1995
  - President-Elect 1995 – 1996
  - President 1996 – 1997
- Boys Hope of Detroit, Board Member; Treasurer and Finance Committee Member
- Health Alliance Plan, Board Member – 1985 – 1988
- Michigan Health Management Information Systems
  - Member, Executive Steering Committee
- Michigan Health and Hospital Association
  - Member, Payment Practices Committee
  - Member, Data Task Force
- Greater Detroit Area Health Council
  - Member, Steering Committee; National Health Information Technology Lab
- Joe Dumars Foundation; Treasurer

AWARDS: HFMA (Healthcare Financial Management Association)

- Chapter Achievement Award of Excellence
- Follmer Bronze Merit Award
- Reeves Silver Merit Award
- Muncie Gold Merit Award
- Certified Fellow

Phi Beta Kappa
Beta Alpha Psi
Licensed Nursing Home Administrator

PERSONAL: Married; four children
Enjoy golf, running, basketball and reading
Private pilot; Certified Flight Instructor, Instrument Rated

James Richard O'Connell

SUMMARY OF QUALIFICATIONS

Forty years of progressive healthcare experience with executive level leadership in both corporate and hospital facilities ranging in bed size from 174 to 522. Geographic locations include Oklahoma, Texas, Florida and Colorado. Major strengths in the development of quality; cost efficient programs; team building; medical staff relations; community relationships and board development and involvement. Have had experience in not for profit, faith based and for profit healthcare facilities.

STRENGTHS

Business turnaround and culture change, program development and strategic positioning, physician / hospital relationship development, patient advocacy, associate engagement and community / board involvement.

PROFESSIONAL EXPERIENCE

Trinity Health

Executive Vice President – East Group
July 2014 to present

Executive Vice President-West/Midwest Group
April 2013 to July 2014

Executive Vice President & Chief Operating Officer
October 2008 to April 2013

TRINITY HEALTH
20555 Victor Parkway
Livonia, Michigan

Centura Health

Executive, Development and Community Relations
Feb 2008 to August 2008

PENROSE-ST. FRANCIS HEALTH SERVICES –CENTURA HEALTHCARE
2222 North Nevada Avenue
Colorado Springs, Colorado

After my resignation as CEO of Penrose St Francis Health Systems, Centura requested me to stay on in the position of Executive Development and Community Relations. Responsibilities include representing the hospital on local community boards. Maintaining the positive image that the team established for the hospital and Centura Health in the community. Additionally, led fundraising efforts and managed the construction of a 460,000 foot Saint Francis Medical Center, completed on time and on budget, and opened 8/8/08. Through the development of this 21st century hospital, we created a sense of excitement in the community to gain a cross section of support for this new facility. Continue to foster relationships with community members and leaders to lay the foundation for the success of my replacement.

Centura Health

President and Chief Executive Officer
May 1999 to Feb 2008

PENROSE-ST. FRANCIS HEALTH SERVICES (522 licensed beds)
2222 North Nevada Avenue
Colorado Springs, Colorado

Led this 522 bed, 3 hospital system to world class recognition, financial and quality performance for over nine years.

- Financial Turnaround: From 1999 operating loss of <$8.5> million, to operating income of $53.6 million in 2007
- National Recognition Solucient's 100 Top Hospitals five times
- U.S. News and World Report Best Systems in the Country 2006 and 2007
- HealthGrades Distinguished Award for Clinical Excellence five years running
- HealthGrades America's 50 Best Award Winner 2007
- Three major construction programs all on time and on budget:
  - Audubon Medical Campus and Surgery Center - $23 million
  - Penrose Main Bed Tower and Medical Office Building - $ 67 million
  - St. Francis Medical Center new 465,000 sq. ft. facility (scheduled to open 8/8/08) - $207 million
- Community and Board Relationships: developed positive community relationships through board involvement, public speaking and community program development
- Physician Engagement: Enhanced physician relations through numerous programs, services and joint venture development all focused on improved quality and patient care
- Associate satisfaction improvement in every annual survey
- Patient satisfaction improvement received consumer choice award last two years
- Recognized as Center of Excellence by Payers in both cardiology and bariatrics

Columbia/HCA **President and Chief Executive Officer**
1995 to April 1999

LUCERNE MEDICAL CENTER (267 licensed beds)
818 Main Lane
Orlando, Florida

- Made substantial impact on the public's awareness and positive perception through continuous community involvement and outreach programs
- Gallup Surveys indicate a continuous increase in-patient, physician and associate satisfaction
- Received Key to the City from the Mayor of Orlando for our active, ongoing partnership in community health
- Developed and received approval from the City of Orlando on our 10-year Facility Master Plan
- Developed active relationship in education with The University of Central Florida
- Planned and completed new expanded Emergency Room facilities to better serve the community
- Increased annual open-heart surgical volume from 176 to 400 cases within a three-year time period
- Received JCAHO Accreditation with Commendation in 1996
- Received 3-year CARF accreditation with no recommendations for our 35-bed rehabilitation facility

Columbia/HCA **President and Chief Executive Officer**
1995 (3 months)

COLUMBIA MEDICAL CENTER DAYTONA (214 licensed beds)
400 North Clyde Morris Boulevard
Post Office Box 9000
Daytona Beach, Florida

Responsible for JCAHO preparation and facility staffing reorganization. Columbia Medical Center Daytona subsequently received accreditation with commendation from JCAHO.

Columbia/HCA
President and Chief Executive Officer
1993 - 1995

PEMBROKE PINES HOSPITAL (301 licensed beds)
2301 University Drive
Pembroke Pines, Florida

Responsible for reversing the hospital's multiple year operational deficit into a progressive profit status for 1994 -1995. Spearheaded operational improvements, new programs (neurosurgery, pediatrics, sleep lab and vascular laboratory) and joint venture / lease of facility to Local Hospital District. Hospital EBDITA increased 170% to $2.3 million prior to lease.

Columbia/HCA
Chief Operating Officer
1992 - 1993

MIAMI HEART INSTITUTE (252 licensed beds)
Miami Beach, Florida

Responsible for the pre-acquisition due diligence for the merger of Miami Heart Institute and Miami Beach Community Hospital. The merged facilities had a total of 531 licensed beds. Plans were developed and executed for departmental resource consolidation. Responsible for overall hospital operations. Administrative representative for all medical staff committees.

Columbia/HCA
Chief Operating / Financial Officer
1991 - 1992

MIAMI BEACH COMMUNITY HOSPITAL (273 licensed beds)
Miami Beach, Florida

Responsible for pre-acquisition and post-acquisition success for this 273-bed, full-service, acute care facility. Direct administrative responsibility for all hospital departments. Actively involved in recruitment and retention of physicians. Served as administrative representative on all medical staff committees. Responsible for successful accreditation by JCAHO and other regulatory agencies. Accountable for all financial operations of the hospital.

AMI
Corporate Director of Operations
1990 – 1991

AMERICAN MEDICAL INTERNATIONAL
Dallas, Texas

Developed analytical framework for analysis of hospitals' performances. Prepared financial comparison and analysis reports. Reviewed hospitals' monthly projections against actual results. Worked closely with hospital CEO's and CFO's to identify opportunities for improvement. Reviewed hospital operating budgets for accuracy and completeness. Facilitated budget training classes for administrative staffs of all AMI hospitals. Developed capital budgeting process for all AMI facilities, including internal rate of return analysis.

AMI

Chief Financial Officer
1989 - 1990

AMI MEMORIAL HOSPITAL TAMPA (174 licensed beds)
Tampa, Florida

Responsible for all financial operations of the hospital. Maintained financial records and statistics needed by the hospital and corporate office for evaluating financial performance, satisfying audit requirements and completing governmental reports. Prepared hospital operating and capital budgets. Prepared financial forecasts for corporate office. Assisted and advised all department heads in the analysis of their department's financial results. Established and maintained the appropriate internal controls in all applicable departments.

AMI

Chief Financial Officer
1987 - 1989

AMI PARKWAY REGIONAL MEDICAL CENTER (412 licensed beds)
North Miami Beach, Florida

Responsible for all financial departments of the hospital. Responsible for the preparation of hospital operating and capital budgets. Prepared monthly financial projections for corporate office. Monitored hospital performance to ensure budgeted goals are met; analyzed and explained variances. Responsible for all contract negotiations. Responsible for the operations of two walk-in clinics and a major diagnostic imaging center. Served as administrative representative on various medical staff committees and board of directors.

AMI

Chief Operating / Financial Officer
1985 - 1987

AMI DOCTORS' MEDICAL CENTER (221 licensed beds)
Tulsa, Oklahoma

Direct administrative responsibility for various hospital support and ancillary departments. Prepared hospital operating and capital budgets. Analysis of income and expense statements. Continually monitored hospital's actual performance versus budget. Feasibility analysis for all projects and ventures. Presented financial review to the board of directors. Assisted in physician recruitment and retention, contract negotiations and joint ventures.

AMI

Manager, Business Operations / Controller
1979 - 1985

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Supervised and coordinated the activities of managers and supervisors. Increased productivity and consistency of business related activities. Assisted chief financial officer in the preparation of monthly financial statements and hospital budgets. Responsible for all accounting functions, including accounts payable, accounts receivable, payroll and quarterly / annual reports.

AMI

Data Processing Manager
1975 - 1979

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Responsible for converting the hospital's manual posting system to a computerized system using an IBM System 3 computer. Wrote and maintained more than 400 user programs, ranging from accounts receivable and payable systems to departmental productivity and budgeting systems.

COMMUNITY

Served on community boards including: Chamber of Commerce, Goodwill Industries, Community Health Partnership, Pikes Peak Education Foundation, El Paso County Equestrian Center, Pikes Peak Humane Society and Joint Initiatives for Families and Children. Led the initiative to create a Detox Continuum for El Paso County. Raised over $15 million in community funds for various projects including the John Zay House, a special project to build an 11 suite home for those receiving extended hospital treatment. This is a project sponsored by the Home Builders Association (HBACares) Recognized as Colorado Springs Business Citizen of the Year in 2004 for community involvement.

EDUCATION

Central State University
Edmond, Oklahoma
B.B.A. December, 1975
Major: Business Administration
Special emphasis in Accounting and Business Law

Oklahoma Baptist University
Shawnee, Oklahoma
May 1974 - May 1975
Major: Hospital Administration

REFERENCES

Available upon request

EXHIBIT 14 a

COMMENTARY

Population Health Management: The Intersection of Concept and Reality

CHRISTOPHER DADLEZ, FACHE

THE FEATURE ARTICLES in this issue of *Frontiers* offer different philosophies and approaches to meeting the Triple Aim of the Institute for Healthcare Improvement. Zenty, Bieber, and Hammack document a local and granular means of creating targeted accountable care organizations (ACOs) to make Triple Aim inroads toward ensuring the health of the discrete populations. Their "build on success" approach offers practical insights on developing mission, governance, and analytics to guide the creation of clinically oriented population health programs, in contrast to the "total population health" ambitions of Kindig and Isham.

Over the past five years, Saint Francis *Care* has been working on many of the same issues and initiatives mentioned in both of the feature articles, from population health management to clinical integration to aligning clinical and social services to developing accountable care models for several payers, including our own hospital, Medicare, and private insurers. Along the way, we have encountered the intersection of concept and reality and forged a path forward.

SAINT FRANCIS *Care*

Saint Francis *Care,* an integrated healthcare delivery system in central Connecticut, is the largest independent Catholic healthcare provider in New England. Our services cover the spectrum of patient needs, including community-based preventive and primary care, specialty care, high-acuity tertiary care, and post-acute care. Many of these services are provided through partnerships, affiliations, and relationships developed with other exceptional providers. Overall, Saint Francis *Care* provides access to almost 900 affiliated physicians, three hospital campuses, 12 satellite medical offices, and a variety of community clinics.

Christopher Dadlez, FACHE, is president and CEO of Saint Francis *Care* Inc. in Hartford, Connecticut.

With 617 licensed beds and 65 bassinets, the flagship of Saint Francis *Care* is Saint Francis Hospital and Medical Center in Hartford. The hospital expanded in 2011 with the addition of the ten-story John T. O'Connell Tower, featuring a state-of-the-art surgical pavilion, dedicated space for the Connecticut Joint Replacement Institute (CJRI), and an expanded emergency department (ED) with 70 treatment areas and a rooftop helipad for the LIFESTAR helicopter. In addition to CJRI, Saint Francis offers centers of excellence in cancer care, heart and vascular disease services, rehabilitation medicine, and women and infants' services. Indeed, Saint Francis opened its 24,500-square-foot Comprehensive Women's Health Center in November 2013, a site that combines breast health, heart health, gynecologic care, and integrative medicine services for women.

Our integrated healthcare delivery system also includes the Mount Sinai Rehabilitation Hospital, Connecticut's only free-standing acute care rehabilitation hospital, which shares space on campus with our Mandell Center for Multiple Sclerosis. In addition, Johnson Memorial Medical Center signed an affiliation agreement with Saint Francis in 2012. The central structure for our ACO is Saint Francis HealthCare Partners, a 50:50 physician–hospital partnership that provides clinical integration and comprehensive administrative support to 700 physicians in more than 200 practices.

A Vision for Value

While we have outstanding facilities, we have long recognized that a well-articulated strategy and aligned providers—not bricks and mortar—are the foundation for advancing healthcare delivery. Back in 2009, Saint Francis *Care* embarked on a unique strategic planning process with an eye toward shaping an organization that would be well positioned to thrive in a changing and uncertain healthcare environment. The core working group was small but represented a diverse mix of administrators, physicians, and board members. *The Innovator's Prescription: A Disruptive Solution for Healthcare,* by Christensen, Grossman, and Hwang (2008), was assigned reading for this group.

From this work, we generated a compelling vision: Best*Care* for a Lifetime. The focus was on delivering value for patients across the continuum of care. In other words—and this was a major shift—we explicitly emphasized the importance of what happens outside the hospital. We were setting the stage to work toward accountable care and saw innovation and a coordinated infrastructure as key drivers.

To achieve the vision of Best*Care* for a Lifetime, our strategic plan called for a new organizational structure, with ten service lines that would set their sights to include the pre-acute/preventive, hospital, and post-acute environments: Behavioral Health, Cardiovascular, CJRI, Emergency Medicine, Medicine, Oncology, Physical Medicine and Rehabilitation, Primary Care, Surgery, and Women and Infants. The work of these service lines is facilitated by robust support platforms that include Business, Clinical Services, and Facilities, as well as our award-winning Innovation + Learning Center. As we had no illusions that a service line model of care was the only key to achieving our vision, the strategic plan also called for becoming a value provider and developing a geographic presence.

By adopting the definition of *value* as outcomes that matter to patients per dollars spent, we leveraged our new organizational structure to focus on the needs of our patients and communities across the continuum of care. To support our

increased emphasis on value, two dozen physicians and executives from Saint Francis have attended Harvard Business School courses presented by professors Michael Porter and Robert Kaplan to engage directly in the latest thinking on value measurement. Armed with a common vocabulary and shared understanding, these leaders were able to reach consensus on a standard Saint Francis approach to not only defining value but also defining outcomes that matter, engaging patients, defining cost, mapping processes, and prioritizing value-oriented projects. We now have a clear mandate for value-driven design across the enterprise, with an aim to deliver value for patients, providers, and payers.

The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved.

While focusing on value is the key to staying ahead of the curve in an accountable care world, the advent of funding based on total cost of care and annual budgets requires a coherent geographic presence. In our very competitive marketplace, we have pursued a clinically integrated network approach to avoid the pitfalls and expense of vertical integration. Our alignment strategy is based on providing as much infrastructure support in as many areas as possible, short of an outright acquisition of the practices. By providing infrastructure support, credentialing, contracting, care coordination, and information technology—as well as requiring compliance with our clinical integration approach—we were able to develop our advanced Clinical Integrated Network.

Involving the Board and Engaging Physicians

As many population health initiatives and activities—even those focused on clinical aspects—are relatively new for most healthcare systems, it is absolutely critical to involve the board of directors and engage physicians as equal partners in the transition from volume to value. Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.

The outcome of that approach was that our board of directors endorsed the recommendation to position Saint Francis HealthCare Partners as the foundation for ACO development, again emphasizing the importance of what happens in physician offices and communities (i.e., not just the hospital). Numerous educational sessions were developed and deployed for the physician community. They were offered at several sites, and physicians were invited to attend at a site of their choice. Our initial aim was to answer as many questions as possible regarding the Affordable Care Act, ACO development, population health, physician requirements, patient engagement, and shared savings.

In terms of governance, we initially created ten ACO committees. More than 170 physicians signed up to participate, with most expressing interest in the Committee on Finance and Shared Savings. The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved. After two years in operation, the ACO committees were merged with the eight physician–hospital organization committees, as there was no need for them to operate in parallel universes.

Today, we have 12 committees, all meeting regularly and generating significant physician feedback. That said, we still have a significant knowledge gap. Although our providers have all received information on ACOs and population health management,

many express confusion or a desire to gain a more thorough understanding. Accordingly, we are working to develop the form and content of appropriately tailored population health education for our providers as well as for our patients and the community.

Accountable Care: Learning While Doing

Much like Zenty, Bieber, and Hammack, we have piloted several accountable care opportunities, all treated as disciplined experiments with the intent of refining our capabilities in preparation for assuming downside risk:

- *Employee ACO.* In an effort to both manage our own spending as a self-insured employer and create a model of what we could do for other large employers, we contracted with Saint Francis HealthCare Partners to create an employee ACO. The principles of accountable care were implemented for 6,500 members, and the combination of plan design changes, care coordination interventions, and wellness incentives yielded a tangible reduction in our cost trend experience.
- *Medicare Shared Savings Program ACO.* In January 2013, Saint Francis HealthCare Partners was awarded a Centers for Medicare & Medicaid Services (CMS) ACO contract covering 20,000 lives. As data from CMS has been fed into our claims data warehouse, we have developed new analytic competencies. In addition, we have embedded care coordinators in our large physician practices and used a public utility model to provide care coordination from a central source for our smaller practices.
- *Commercial ACOs.* Private payers quickly got up to speed with accountable care payment mechanisms. In the past year, Saint Francis HealthCare Partners entered into two commercial ACO arrangements, covering another 55,000 lives. Both of these commercial agreements have similar structures based on a total cost of care (i.e., population health management) model.
- *Bundles.* CJRI is a leading-edge program on a number of levels; for example, it offered one of the first bundled products for hip or knee replacement in the United States. These joint bundles include payment for surgeons, anesthesiologists, and the hospital. An additional postsurgical warranty rider is also available.
- *Care coordination.* Saint Francis employs a structured care coordination model, with staffing based on national norms. Covered lives are stratified by health risk, and health coaches are assigned to the highest-risk patients for interventions. Mechanisms to address gaps in care, transitions in care, ED follow-up, and discharge appointment follow-up are all part of the program.

Population Health (Not Just Healthcare)

Operating as a Medicare Shared Savings Program ACO, building an employee ACO, working with private payers to develop new commercial ACO arrangements, offering bundles to the marketplace, and ramping up an enterprise-wide care coordination program all depend on a population health management infrastructure that continues to require significant investment in personnel and information technology. We have successfully built such an infrastructure, but we know our work is not nearly done. A focus on clinical care and clinical integration is

insufficient as we move to an environment in which healthcare providers are accountable for broadly defined health outcomes. In other words, it's not just healthcare. In the context of population health, the big picture includes behavioral and social determinants of health. The key question is whether—and how—healthcare systems can influence these determinants or integrate community and social services that can.

In highlighting the total population health approach, Kindig and Isham also shed some light on why current approaches focus on clinical health for populations. They refer to the definition of population health used by the Institute of Medicine's Roundtable on Population Health Improvement: "The health outcomes of a group of individuals, including the distribution of such outcomes within the group." Given that scope, no one should be surprised or disappointed that healthcare organizations would focus on clinical care. Not only is it their expertise, but the emphasis on outcomes seems to support a clinical approach as well. However, clinical care improvement is only part of the original concept developed by Kindig and Stoddart (2003), which offers a broader and deeper view of population health as encompassing "the definition and measurement of health outcomes and their distribution, the patterns of determinants that influence such outcomes, and the policies that influence the optimal balance of determinants."

Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.

It is this expanded view that animates the total population health concept offered by Kindig and Isham. Indeed, perhaps most compelling in their article is the statement that "the contribution of healthcare to health is modest—only 20 percent—a fact that many healthcare leaders may find surprising." *Stunning* may be the better word choice here, particularly because other research suggests that 20 percent might be a generous estimate. The other 80 percent of healthcare determinants are identified as health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent)—items outside the control of traditional healthcare delivery systems. This finding challenges the paradigm that has tipped the balance toward sick care instead of healthcare.

That many of our patients struggle with behavioral and social determinants of health is not news. But what is the extent to which healthcare organizations can and should productively partner with patients, communities, and community-based support/social services organizations to address these determinants and improve outcomes? Different healthcare organizations will have different answers to this question. At Saint Francis, we have been working hard to engage all those partners when appropriate. (We say "when appropriate" because not all patients need social services. But for those who do, these services are the rate-limiting step for some patients. In other words, if people cannot take care of their lives, they will have a hard time taking care of their health.)

We have been learning real-world lessons for more than two years as our Emergency Medicine and Primary Care service lines work with our Innovation + Learning Center and Saint Francis HealthCare Partners to improve emergency medicine–primary care coordination. Much of this work has focused attention on the relatively small number of patients who account for a disproportionately large share of ED visits. We developed a robust ED registry that helped us move from

lamenting high *utilization* to getting to know our high *utilizers*. We are now making concerted efforts to integrate clinical services, to focus on care coordination—which includes coordinating the coordinators—and to partner with community and governmental organizations in building a network of care that historically would have been considered outside the purview of a hospital, much less healthcare in general. This is a step toward the community health business model promoted by Kindig and Isham.

Accountable Care Communities

Some of our efforts reflect a move toward an accountable care community (ACC) model that bridges clinical and community settings to address both the medical and the social needs of high-risk, high-cost, or vulnerable patients in an integrated manner consistent with the Triple Aim. In fact, we partnered with Community Solutions and the Department of Mental Health and Addiction Services in Connecticut—as well as with NuHealth, the Health and Welfare Council of Long Island (NY), and Health Leads on Long Island—to submit a proposal to CMS's Center for Medicare & Medicaid Innovation (CMMI) for developing ACCs in Hartford County and Nassau County.

Accountable care community is a term that was first employed by the Austen BioInnovation Institute in Akron (ABIA) to describe a multisector, community-based collaborative effort to transform healthcare in Northeast Ohio. The ABIA (2012) defines an ACC as

> *A collaborative, integrated, and measurable strategy that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services, and healthcare delivery. . . . It builds on initiatives to encompass not only the area's medical care providers, but also the public health system and community stakeholders whose work, taken together, spans the spectrum of the determinants of health.*

The National Governors Association (2013) suggests that ACCs "take the concept of medical homes and accountable care organizations one step further by fostering collaborations borne of shared responsibility among clinical and community sector participants to reform health systems in particular localities." Kindig and Isham mention ACCs as one model with the potential for addressing total population health.

The Integrator Role

Kindig and Isham appropriately highlight the importance of an "integrator," an organization that will pull together the various clinical and social services. Whether we like it or not, given our community presence, hospitals and healthcare organizations will be at the center of these population health dynamics. And even if we account for only 20 percent of health outcomes, we may always be expected by our communities and by business and government sectors to provide central leadership and do the population health "heavy lifting." That expectation will require that we play a role in both clinical and social initiatives. Finding the appropriate mix between the two will be a challenge for any provider. The HealthPartners example featured by Kindig and Isham and similar initiatives will be rare examples indeed unless and until payment models support this kind of work. But it is possible. As a point of reference, the actuarial analysis conducted for our CMMI proposal forecasted a reduction in Medicaid spending

that would produce shared savings sufficient to sustain the ACC program in both Hartford County and Nassau County.

The Hartford region has a highly competitive healthcare landscape, which raises another set of fundamental questions: Can total population health be achieved in a competitive clinical environment? Can the healthcare organizations work together? And how? Providers are in the midst of changing the clinical business model, but is it even more important to develop a sustainable model for integrating clinical services and social services to address the social determinants of health? As might be expected for any new endeavor, there are more questions than answers. But some answers are starting to emerge.

Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.

For instance, Saint Francis, along with the other major hospitals in Hartford, provided funding for the City of Hartford's *Community Health Needs Assessment* report. Scheduled for publication every three years, the first edition was released in March 2012 by the city's Department of Health and Human Services. This study examines the social determinants of health—income, shelter, education, access to nutritious foods, community norms, and cohesion—that affect the health of Hartford residents. The key will be to move from funding the documentation of needs to addressing them in a coherent and sustainable manner.

Conclusion

We may all agree that addressing the social determinants of health is the critical path toward "total population health" and, ultimately, health equity. But we must also acknowledge that moving from concept to real-world action will require significant start-up investment that cannot come from the providers alone. Achieving this complex transformation of care at the population level requires that we align our payment systems, our healthcare delivery systems, and our community support systems. Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.

Acknowledgments

The work ahead requires leaders to gather the collective minds of the thought leaders around us and together create the foundation to advance the delivery of healthcare. I would like to acknowledge the Saint Francis *Care* thought leaders who have contributed their expertise to this commentary: Gregory Makoul, PhD; Danyal Ibrahim, MD; Surendra Khera, MD; Adam Silverman, MD; Jess Kupec; and James Schepker.

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EXHIBIT 14 b

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
HEALTH PROGRESS

Today's Transformational Mission: Opportunity Abounds to Bring More People Better Care

September-October 2015
By: Richard J. Gilfillan, MD

Times of great change and uncertainty breed opportunity. Entrepreneurs create new ways to meet customer needs. Leaders of established organizations explore new ways of operating. One common solution to the challenge created by change is to partner with other organizations with capabilities that fit new marketplace demands.

American health care illustrates this phenomenon well today. Alternative care delivery and reimbursement models challenge us to discover new ways to deliver better outcomes. Exchange-based insurance products demand value networks at a time when we are just learning how to best measure quality and value. As a result, we are changing our business and clinical models without really knowing what care systems work best or how the outcomes will be evaluated. Amid all this change and uncertainty, it is no surprise that we have unprecedented levels of entrepreneurial startups, mergers, acquisitions and consolidations.

As with many other Catholic health systems, Trinity Health, based in Livonia, Michigan, believes that today's challenges are merely the entrance fee for taking on great opportunities to advance our mission. In fact, we believe there has never been a better time for Catholic health care to have a positive impact on our communities and the people we serve. These new models offer the opportunity for us to be rewarded for what our mission now calls us to do — provide excellent coordinated care to as many people as possible. This objective seems to be the natural evolution of the challenge our founders overcame as they spread across the country to provide direct acute patient care to individuals in need.

BUILT ON A BOLD FOUNDATION

The story of Trinity Health, as with most of Catholic health care, began more than 150 years ago when congregations of women and men religious answered the call to help heal and minister to people in need across the United States. These women and men traveled far and under tough conditions to serve others, especially vulnerable and marginalized populations. In the context of their times, these remarkable individuals built facilities and developed services from almost nothing, then continually looked at what they

could do next to help more people. Their efforts have resulted today in Catholic health care providing 16 percent of all hospital care in our country.

It is inspiring to ponder what called these women and men to be so outrageously bold. Clearly, they were driven by their commitment to service, to being a healing presence in the communities they served. In pursuit of their mission, they were willing to take risks, some of which probably seemed extreme. At times, they were torn between going slower and trying to do too much too soon. They chose to err on the side of moving forward assertively. They understood they could not linger until the right choices became obvious and that inaction carried risks of its own. In the face of great uncertainty, they moved boldly forward.

Today we are poised upon this foundation to build the health care system that our country needs for tomorrow. There are great uncertainties and risks associated with transforming our system, but we do not come from a legacy of excessive caution. That is why, at Trinity Health, we have framed a strategic transformation effort to build a people-centered health system — designed and operated to put the needs of people we serve at the center of all we do. We believe this strategy injects the bold intent of our founding congregations' missions into our work today.

Delivering people-centered care will require us to have many new operational capabilities. We will build some of these ourselves; others we will gain through partnerships with organizations that have more experience and skill. Across Catholic health care, we have seen many creative approaches to partnerships. Systems are collaborating with for-profits and not-for-profits, creating networks of nontraditional alliances and forming subsidiaries in areas such as research, insurance, telemedicine, home health, information technology and physician practice management.

MISSION IN ACTION

Our strategic plan, "People-Centered 2020," puts our mission into action and includes several key components. The first is to transform the way we deliver and are paid for providing care. To accomplish this, we have moved aggressively to develop new internal capabilities like our accountable care organization expertise. Although the Centers for Medicare and Medicaid Services' post-Affordable Care Act reimbursement playbook is still evolving, we have established Medicare Shared Savings ACOs in 18 of our 21 Regional Health Ministries. We have built out a set of new population health management activities that are essential for operating a successful ACO clinical and business model.

We also are participating broadly in the CMS Bundled Payments for Care Improvement program, with 53 facilities (38 hospitals, 12 continuing care facilities and three home health agencies) contracted for 40 different episodes of care as of Oct. 1, 2015. We are partnering with several different organizations that bring specific expertise in managing episode-based clinical models.

We also have partnered with other parties to build expanded provider networks. In Michigan, we partnered with Ascension to co-found Together Health Network, a physician-led, statewide, clinically integrated network of 25 hospitals and hundreds of ambulatory centers and physician offices. The network enables its member hospitals, physicians and other providers to jointly participate in the launch of new health plan products that give consumers greater choice and access to value-based health care services. Across our entire system, we have partnered with payers to establish 12 new value network products to date; with 18 more in development.

To develop the ability to manage full-risk capitation with payers, we established a joint venture, Trinity Health Partners, with Heritage Provider Network. Heritage has a 30-year history of successful contracting with insurers for full-risk capitation. This joint venture will develop care networks similar to ACOs, including primary care physicians, hospitals, clinics and other providers who join together to manage care for populations of patients. These networks will contract with insurers to assume full financial risk for managing these populations, which means they will be paid a set amount per patient and will be fully

responsible for covering any costs that exceed the payment. The Heritage relationship provides us with access to operational capabilities that have demonstrated success under capitation arrangements.

During the past year, we have formed a clinical care partnership with Walgreens to explore new possibilities provided by retail vendors. They will offer their stores in our facilities in select markets — enabling outpatient pharmacy services and expanded prescription and disease management programs to support people's health, while at the same time increasing consumers' access and lowering overall health care costs. We also are partnering with the Sharecare company to provide a digital consumer engagement platform. It provides a state-of-the-art, online environment that supports millions of people in their efforts to live healthier lives, and it helps them connect with physicians and remain personally engaged in their ongoing care.

Our plan also calls us to attempt to impact the transformation of our system nationally. That is why we joined with a group of Catholic health systems including Ascension, OSF Healthcare, Providence Health & Services, SLC Health and SSM Health, as well as other industry participants, to form the Health Care Transformation Task Force. Its goal is to bring together like-minded providers, payers, employers and patient advocacy groups to facilitate the path to transformation. Members include six of the nation's largest 15 health systems and four of the largest 25 health insurers. Together, we have committed to put 75 percent of our business into value-based arrangements that focus on better health, better care and lower costs by 2020. The task force has produced a number of policy recommendations, including several to CMS and the federal Department of Health and Human Services that we believe are helping to drive payment changes that support our transformation goals.

Our "People-Centered 2020" plan envisions significant growth in current communities, as well as expansion into new communities. Just as our founding congregations constantly reached out to new populations, we recognize that with the change and uncertainty in health care, there are significant opportunities to support existing Catholic health care ministries in communities that we do not serve today.

Our objective is not simply to be larger. It is to be an effective partner capable of bringing real value to regional Catholic health systems pursuing a similar mission. We believe we can provide significant economies of scale to some ministries, along with more sophisticated operational capabilities that allow them to continue their regional missions. These partnerships allow us to bring new ideas and competencies to smaller regional ministries faster. These are two-way partnerships. Within them, we share our knowledge and also learn from our new local ministries, identifying best practices that we can spread to other ministries in our system.

Our growth team, under Scott Nordlund, has developed a set of screening criteria to help us identify appropriate partners. These criteria look at a full range of operational dimensions, but start with an evaluation of mission alignment.

On July 1, 2015, St. Joseph's Health in Syracuse, New York, became a part of Trinity Health. (See story, page 18). This partnership extends our healing ministry to central New York, complementing our presence in Buffalo and Albany. We also signed a definitive agreement with Saint Francis Care, a health delivery system anchored in Hartford, Connecticut, to join Trinity Health. This merger expands our ability to work with community physicians and clinicians, providing better care coordination for people across New England, and extends Catholic care in the region.

RESPONSIBLE RISKS

Our strategy, of course, is not without risks. Our board and our leadership team often reflect on our legacy. They recognize that those who founded our organizations answered the call to help heal and minister to communities across the United States and faced far greater risks. They led the way, leaving a legacy of bold leadership for us to follow.

All health care organizations and leaders, not just those in Catholic health care, are living in this challenging environment of constant change and uncertainty. We all are struggling with the same issues of how far to move and how fast. Based on how we are working together in the task force, and what I hear as I talk with other health system leaders, I believe we are poised at a point where a transformation to a people-centered health system is possible. As leaders, we know that today's challenges offer us the once-in-a-lifetime opportunity to make our health care system right for our children and our country.

My hope is that, individually and collectively, we will seize this opportunity. We will need to be creative internally and externally, and that includes rethinking our approaches to operations and partnerships and always assessing our choices for alignment with our mission. As mission-driven organizations grounded in service to our communities, Catholic health systems are perfectly positioned to lead the way and build this new system of health care.

RICHARD J. GILFILLAN is president and CEO of Trinity Health, Livonia, Michigan.

EXHIBIT 15

Naugatuck Valley Women's Health Specialists

www.nvwhs.com

David Polke, MD
S. Mark Albini, MD
Irina Magidina, MD
Melanie B. Mund, MD
Deborah Garber, CNM

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

687 Straits Turnpike, Suite 2A • Middlebury, CT 06762
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I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

S. Mark Albini, M.D.

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ARTHUR J. O'NEILL
SIXTY-NINTH ASSEMBLY DISTRICT

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CHAIRMAN
LAW REVISION COMMISSION

MEMBER
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JUDICIARY COMMITTEE
REGULATION REVIEW COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

October 22, 2015

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based

accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur J O'Neill

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

Franklin Medical GROUP

Rohit Beri, MD, FCCP

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

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Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

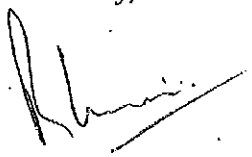
As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve

is approved, it will allow Saint Mary's physician's access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



Rohit Beri, MD, FCCP
Director, Medical ICU
St. Mary's Hospital
Waterbury, CT

Franklin Pulmonary Group *133 Scovill Street, Suite 104* *Waterbury, CT 06706*
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State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ANTHONY J. D'AMELIO
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HOUSE REPUBLICAN WHIP

MEMBER
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's is a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

Family Footcare, PC
James M. DeJesus, DPM, FACFAS
David W. Mader, DPM, FACFAS
Betty M. Carreira, DPM

November 11, 2015

Kimberly R. Martone
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77 Main St North · Suite 104 · Southbury, CT 06488 · Phone (203) 405-6501 · Fax (203) 405-6504

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James M. DeJesus, DPM, FACFAS

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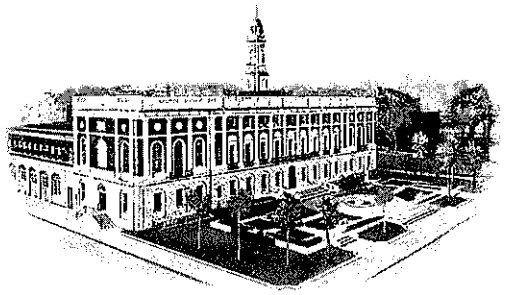

DEPARTMENT OF PUBLIC HEALTH

THE CITY OF WATERBURY

CONNECTICUT

October 26, 2015

Kimberly R. Martone
Director of Operations
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Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

William Quinn
Director of Public Health
Waterbury Health Department

NOSS
Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery
Michael E. Karnasiewicz, MD, ABNS
Neurosurgery & Spine Care
Jarob N. Mushaweh, MD, ABNS
Neurosurgery & Spine Care
Alan S. Waitze, MD, ABNS
Neurosurgery & Spine Care
John G. Strugar, MD
Neurosurgery & Spine Care
David L. Forshaw, MD
Neurosurgery & Spine Care
Judith L. Gorelick, MD, FAANS, FACS
Neurosurgery & Spine Care

Orthopaedics
Glenn G. Taylor, MD, ABOS
Orthopaedic Surgery & Spine Care
William F. Flynn, Jr., MD, ABOS
Joint Reconstruction & Sports Medicine
Frederick J. Watson, MD, ABOS
Orthopaedic Surgery & Sports Medicine

Pain Management
and Rehabilitation
Tamer B. Ghaly, MD
Interventional Pain Management
Thomas Mathew, MD
Interventional Physiatry
Alisa H. Darling, MD, ABPMR
Physical Medicine & Rehabilitation
Electrodiagnostic Medicine
Mark A. Mashia, DC, MS
Chiropractic Physician, Acupuncture

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System.

Main Office 500 Chase Parkway, Waterbury, CT 06708
Satellite Offices Shelton, CT - Southbury, CT - Torrington, CT
Phone (203) 755-NOSS (6677) (800) 463-8764
Fax Neurosurgery: (203) 573-9182 Orthopaedics: (203) 755-7166 Spine/physiatry: (203) 573-1272
Web www.nossmd.com

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

Saint Bridget Church

November 06, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, Connecticut 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

As a concerned citizen, and a local Pastor, I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful in this ever-changing and challenging environment. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

175 Main Street, Cheshire, Connecticut 06410
Phone 203-272-3531 • Fax 203-271-3356

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's Health System has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Jeffrey V. Romans

The Reverend Jeffrey V. Romans
Pastor

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

November 5, 2015

Ms. Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
P.O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

As a non-profit social service organization in Waterbury, it is very important to me who is in charge of operating the Hospital and its outpatient services. Saint Mary's has an outstanding reputation for its quality of patient care. I believe that Trinity, which now includes Saint Francis Care as one of its partners, will add to that quality, by leaving most of the Saint Mary's services as they are today, but with the financial resources to make existing services even better. Access to capital, as well as funding during the first five years after the acquisition, will make Saint Mary's stronger and more able to meet the needs of the community.

I strongly recommend you approve the application submitted by Saint Mary's and Trinity Health Corporation.

Respectfully submitted,

James M. O'Rourke
Chief Executive Officer

136 West Main Street, Waterbury, CT 06702 p: 203-754-YMCA f: 203-754-9095 www.waterburyymca.org

State of Connecticut

SENATE

SENATOR JOE MARKLEY
SIXTEENTH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
CAPITOL: (860) 240-0381
TOLL FREE: (800) 842-1421
E-MAIL: Joe.Markley@cga.ct.gov
WEBSITE: www.SenatorMarkley.com

ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN

RANKING MEMBER
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

Franklin Medical
GROUP PC

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint

Kimberly R. Martone
Office of health Care Access
November 12, 2015

Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Paul Kelly, MD
Chief of Cardiology

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE LEZLYE ZUPKUS
EIGHTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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FAX: (860) 240-0207
Lezlye.Zupkus@housegop.ct.gov

RANKING MEMBER
PUBLIC SAFETY AND SECURITY COMMITTEE

MEMBER
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

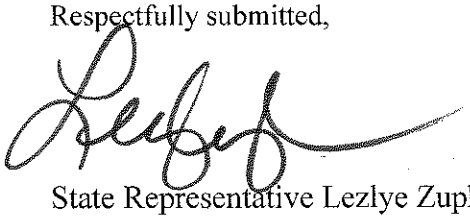
The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

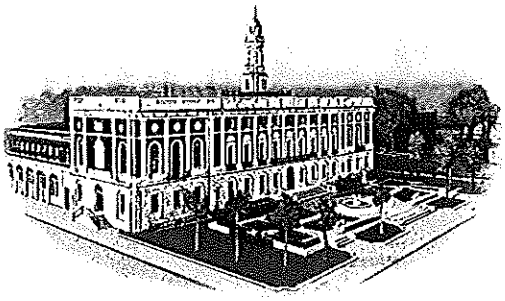
Respectfully submitted,



State Representative Lezlye Zupkus

NEIL M. O'LEARY
MAYOR

JOSEPH A. GEARY
CHIEF OF STAFF



OFFICE OF THE MAYOR
THE CITY OF WATERBURY
CONNECTICUT

October 21, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

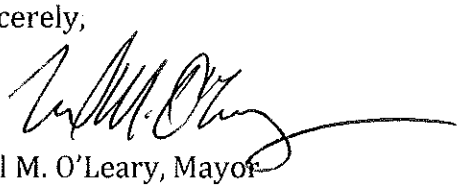
I am writing in support of Saint Mary's application to become part of the Trinity Health Corporation. This acquisition by Trinity will allow Saint Mary's to become affiliated with Saint Francis Care in Hartford as well as Trinity. Saint Francis and Saint Mary's will become part of a Regional Health Ministry in Connecticut (NE-RHM) that will include hospitals and health systems in western Massachusetts as well. By joining Trinity's network of over 86 hospitals in the country, Saint Mary's will have access to a vast range of services and initiatives such as clinical quality initiatives, information technology and supply chain initiatives as well as the financial support that comes as part of a larger network. Financial support is critical in order to meet higher health expectations that have developed in the past few years. Saint Mary's is an outstanding community hospital serving the people of this City, and it needs support from a larger network to continue to provide the same excellent care to a growing number of people.

The demands of the new healthcare laws and the expense of operating a large hospital in downtown Waterbury and a system with 18 service towns will put enormous pressure on Saint Mary's in the future. Trinity is capable of helping Saint Mary's continue to provide exceptional care to the people of Waterbury and the greater Waterbury community. Saint Mary's carefully considered other alternatives,

but found that Trinity had the philosophy and commitment to the same core values that Saint Mary's has maintained for over one hundred years. Top among these values are fulfilling the community-based mission, delivering quality care and adhering to the Ethical and Religious Directives that are part of Saint Mary's Catholic identity.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc. and the Regional Health Ministry formed in CT by Trinity Health Corporation and Saint Francis Care, Inc.

Sincerely,



Neil M. O'Leary, Mayor

SS. Peter & Paul Church

67 Southmayd Road

Waterbury, CT 06705

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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Kimberly R. Martone
CT DPH Office of Health Care Access
[Date]

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

[Name]

Saint Mary's
HOSPITAL

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

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Saint Mary's
HOSPITAL

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Philip R Corvo MD MA FACS.

Philip R Corvo MD MA FACS
Chairman, Department of Surgery
Director, Surgical Critical Care
Stanley J Dudrick Department of Surgery
Institutional Official
Saint Mary's Hospital, Waterbury, Connecticut
Governor-At-Large, American College of Surgeons
Past President, Connecticut Chapter of the American College of Surgeons
Past Health Commissioner, City of Stamford

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ANTHONY J. D'AMELIO
SEVENTY-FIRST ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

TOLL FREE: (800) 842-1423
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Anthony.DAmelio@housegop.ct.gov

HOUSE REPUBLICAN WHIP

MEMBER
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

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I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ARTHUR J. O'NEILL
SIXTY-NINTH ASSEMBLY DISTRICT

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FAX: (860) 240-0207
Arthur.ONeill@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

CHAIRMAN
LAW REVISION COMMISSION

MEMBER
APPROPRIATIONS COMMITTEE
JUDICIARY COMMITTEE
REGULATION REVIEW COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

October 22, 2015

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CRAIG A. MINER
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
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Craig.Miner@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
State Representative
66th District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE DAVID K. LABRIOLA
ONE HUNDRED THIRTY-FIRST ASSEMBLY DISTRICT

185 RIGGS STREET
OXFORD, CONNECTICUT 06478
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FAX: 860-240-0207
David.Labriola@housegop.ct.gov

HOUSE REPUBLICAN WHIP

MEMBER
TRANSPORTATION COMMITTEE
GOVERNMENT ADMINISTRATION AND ELECTIONS COMMITTEE
JUDICIARY COMMITTEE

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

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We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Dave

David Labriola
State Representative
131st District
Naugatuck and Oxford

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

Representative David Zoni
81st Assembly District
Southington

Legislative Office Building
Hartford, Connecticut 06106
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David.Zoni@cga.ct.gov

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

State Representative David Zoni
81st District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ERIC C. BERTHEL
SIXTY-EIGHTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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Eric.Berthel@housegop.ct.gov

MEMBER
EDUCATION COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
PUBLIC HEALTH COMMITTEE

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Eric C. Berthel
State Representative – 68th District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE LEZLYE ZUPKUS
EIGHTY-NINTH ASSEMBLY DISTRICT

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RANKING MEMBER
PUBLIC SAFETY AND SECURITY COMMITTEE

MEMBER
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

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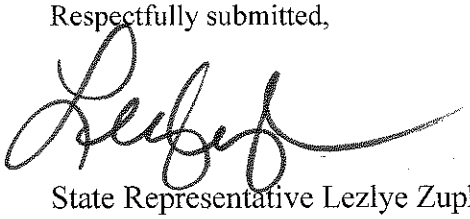
I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,



State Representative Lezlye Zupkus

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE SELIM G. NOUJAIM
SEVENTY FOURTH ASSEMBLY DISTRICT

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WATERBURY, CT 06705

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Selim.Noujaim@housegop.ct.gov

HOUSE REPUBLICAN WHIP

CHAIRMAN
REGULATIONS REVIEW COMMITTEE

MEMBER
COMMERCE COMMITTEE
EXECUTIVE AND LEGISLATIVE NOMINATIONS
INTERNSHIP COMMITTEE

Date: October 23, 2015

Ms. Kimberly R. Martone, Director of Operations

CT Department of Public Health

Office of Health Care Access

410 Capitol Avenue PO Box 340308

Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System

and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully,

Selim G. Noujaim

Selim G. Noujaim

Saint Mary's
HOSPITAL

Department of Dentistry

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area.

Kimberly R. Martone
Office of Health Care Access
November 11, 2015

Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Richard Putnam, D.M.D., F.A.G.D.
Chief, Department of Dentistry
Director, GPR Program
Saint Mary's Hospital
133 Scovill Street
Waterbury, CT 06706
203-709-7055 - phone
203-709-7750 -fax
richard.putnam@stmh.org

Waterbury ORTHOPAEDIC ASSOCIATES, PC

ERIC J. OLSON, M.D.
DENNIS M. RODIN, M.D.
MICHELLE MARIANI, M.D.

ALAN HOULE, PA-C
PAM NOLE, ADMINISTRATOR

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

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1211 West Main Street
Waterbury, CT 06708-3178
Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

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Sincerely,

Dennis Rodin, MD

1211 West Main Street
Waterbury, CT 06708-3178
Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

Main St. Waterbury

Culture Education Business

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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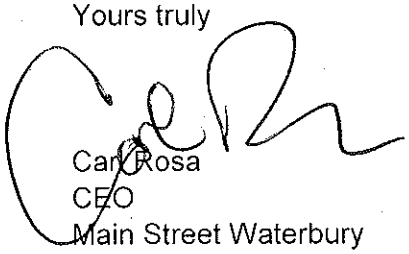
I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Yours truly



Carl Rosa
CEO
Main Street Waterbury

CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C.

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY
HEARING, BALANCE DISORDERS & FALL PREVENTION CENTER

Neil F. Schiff, M.D.
Mahesh H. Bhaya, M.D.
Board Certified in Otolaryngology

Deborah A. Mastriani, APRN

Dana K. Cipriano
Practice Administrator

Specializing in all aspects of:
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Speech & Swallow Evaluation
Voice Evaluation & Management
Laser Surgery
Allergy Testing & Treatment
Apnea and Snoring Procedures
Hearing Evaluation
Hearing Aid Dispensing
Balance Disorders & Fall Prevention

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Fax (203) 755-1708

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Fax (203) 264-2920

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Apple Valley Mall
Southington, CT 06489
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Fax (860) 276-0828

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November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

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I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely yours,

NF Schiff MD

Neil F. Schiff, M.D.
President, CT ENT
Fellow AAO/HNS

State of Connecticut

SENATE

SENATOR JOE MARKLEY
SIXTEENTH DISTRICT

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ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN

RANKING MEMBER
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

State of Connecticut
SENATE

SENATOR ROBERT J. KANE
THIRTY-SECOND DISTRICT

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WEBSITE: www.SenatorKane.com

DEPUTY MINORITY LEADER PRO TEMPORE &
CAUCUS CHAIRMAN FOR POLICY

RANKING MEMBER
APPROPRIATIONS COMMITTEE
EXECUTIVE & LEGISLATIVE NOMINATIONS COMMITTEE

MEMBER
PUBLIC HEALTH COMMITTEE

10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Senator Rob Kane – 32nd District

Saint Mary's
HOSPITAL

11/12/15

Michael Simms III, MD, ABIM (ID)
Infectious Diseases
56 Franklins St.
Waterbury, CT 06706
203-709-6402

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

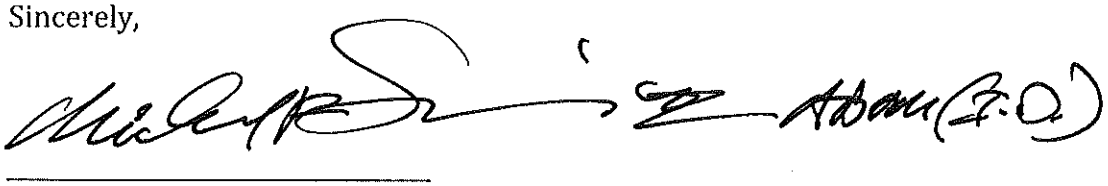
As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint

Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



Waterbury Regional Chamber
driving business to business

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired by Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a nonprofit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health, as well as Saint Francis Care and Saint Mary's, are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and standalone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. Saint Mary's merger with Saint Francis Care, together with their ultimate acquisition by Trinity Health, will give both Catholic hospitals the support needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

Waterbury Regional Chamber
driving business to business

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

We have known for a long time that Saint Mary's was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options for a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Lynn G. Ward

Lynn G. Ward
President & CEO
Waterbury Regional Chamber
83 Bank St., Fourth Floor
Waterbury, CT 06721
203-757-0701, Ext. 310
lward@waterburychamber.com

ABDULMASIH ZARIF, M.D., LLC
BOARD CERTIFIED
GENERAL, LAPAROSCOPIC AND CANCER SURGERY

November, 06, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

RE: Certificate of Need Application seeking approval for Saint Mary's Health system and its subsidiaries to be acquired as part of trinity health corporation.

Dear Ms.Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

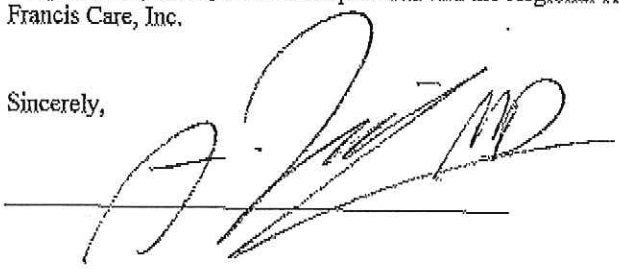
Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make to Saint Mary's over five years will, in part, be used for the community health/population management initiatives, physician network and development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality of care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health" an alliance with Yale New Haven Health System.

I recognize thew challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that the health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with the resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



1389 West Main Street • Tower 2 - Room 321 • Waterbury, CT 06708 • (203) 757-1113 • Fax (203) 575-9018

EXHIBIT 16

EXHIBIT
List of Residencies

The following is a list of residencies offered at Saint Francis through the University of Connecticut School of Medicine:

* Anesthesiology
* Emergency Medicine
* Family Medicine
* Pediatrics
* Internal Medicine (General)
* Internal Medicine (Cardiology)
* Internal Medicine (Endocrinology)
* Internal Medicine (Gastroenterology)
* Internal Medicine (Hematology/Oncology)
* Internal Medicine (Infectious Disease)
* Internal Medicine (Pulmonary/ Critical Care)
* Maternal Fetal Medicine
* Nuclear Medicine
* Orthopedic Surgery
* Otolaryngology
* Psychiatry
* Radiology
* Surgery
* Urology
* Geriatric Medicine
* Nephrology
* Primary Care Medicine

The following are the Saint Francis Residency and Fellowship programs:

* General Dentistry Residency
* Obstetrics and Gynecology Residency
* Podiatric Medicine and Surgery Residency
* Colon/Rectal Surgery Fellowship

EXHIBIT 17

Exhibit 17

Financial Worksheets

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

Financial Worksheets including actual and projected results have been prepared for both consolidated Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital (only). FY 2015 actual results are preliminary unaudited results.

General Assumptions:

- For all years, the Hospital Tax has been reclassified as an "Other Deductions" line A.4 to be consistent with Trinity Health - New England for presentation purposes.
- FY 2015 actual results include a $2.9 million receivable from the State of Connecticut for the 1st quarter supplemental payment associated with the Hospital Provider Tax for the State's FY 2016. If the State further reduces funding, actual results may differ. This amount is included in "Other Deductions", Line A.4.
- The FY 2016 revised budget includes the assumption that the State will resume the supplemental payments in the 4th quarter of FY 2016 (or 1st quarter of State FY 2017) of $2.9 million.
- As a result of the decrease in State supplemental payments, the FY 2016 budget was revised and includes the following:
    - A net increase of 117 full-time equivalents was reduced to 74 as a result of delayed hiring for open positions. In addition, the wage increase for FY 2016 was reduced to 2%,
    - Related employee benefits were also decreased approximately 3%, and
    - Other cost reduction initiatives approximating $2.3 million.
- FY 2017-2019 assumes the State Provider Tax will remain at the same level as included in the FY 2016 revised budget.

The following summarizes key assumptions used in projecting the FY 2017 - 2019 operating results:

- Inpatient volume is projected to decrease .5% each year, respectively, from FY 2017 through FY 2019 as utilization of inpatient services shifts as a result of population health management.
- Outpatient visits is projected to increase 2% each year, respectively, from FY 2017 through FY 2019 as preventive care increases as a result of population health management.
- An increase in Medicare reimbursement is included in FYs 2017-2019 as a result of a change in the Medicare wage index.
- Bad debts as a percentage of gross revenues are expected to remain flat.
- Projected salary and benefits expense includes increases of 2.5% for FY 2017 through FY 2019. While overall FTE's remain flat, the increase represents employee merit/inflation increases.

- Supplies and other expenses include inflation increases between 2%-5% for FY2017 through FY 2019.
- The existing CHEFA debt was refinanced in 2015, resulting in a reduction in Interest Expense in FY 2016-2019, Operating Expenses - Line 7.

Based on Trinity Health's historical success with the integration of hospitals and health systems into the Trinity Health system, it is expected that operational savings of approximately 1% of current annual operating expenses or $3.1 million will be realized. The incremental projected amounts are included in the financial worksheets beginning in FY 2017, realizing 50%, as we anticipate a closing on or around July 1, 2016. In FY 2018, we anticipate realizing the full 1%. Some areas where we expect to recognize these opportunities include purchased services, supply chain, insurance and risk management, treasury, tax and compliance. These reductions have been included in the financial worksheets in Lines 4 Supplies and Drugs and Line 10 Other Operating Expenses.

There are no planned changes to the clinical services offered by SMHS as a result of this transaction; however, as part of its population health and other health reform initiatives, the parties may, in the future, choose to make changes in the services offered by Trinity Health - New England or its subsidiaries that are intended to best meet the communities health care needs.

In addition to the expected operational savings noted above, the known significant financial benefits to SMHS are as follows:

- As previously noted on page 15 of the CON application, a commitment by Trinity Health to ensure investment of $100 million dollars (potentially up to $120 million) in capital that will allow SMHS to:
    - Address equipment replacement and routine facility upgrades that have been delayed due to the recent reductions in state and federal healthcare funding; and
    - Make additional strategic investments in healthcare initiatives as opportunities arise over the next 5 years, including those necessary to move towards risk-based contracting.

    Refer to page 72-73 of the CON application for approximate allocation of capital spending and needs.

- Ability to access capital financing at favorable rates through Trinity Health - New England via Trinity Health's intercompany loan program.
- Support to enable SMHS to adequately fund its pension obligations.
- Access to Trinity Health - New England and Trinity Health system services to promote efficient and effective care delivery.

Note: The impact of the financial commitment by Trinity Health of $100 million (potentially up to $120 million) has not been included in the projections because the allocation of these funds has not yet occurred.

If any proposed investment requires additional regulatory approval, this approval will be obtained prior to the investment being made.

NON-PROFIT

Saint Mary's Health System, Inc.

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$832,217	$873,828		$873,828	$917,519		$917,519	$963,395		$963,395	$1,011,565		$1,011,565
2	Less: Allowances	$535,300	$558,162		$558,162	$592,210		$592,210	$628,335		$628,335	$666,663		$666,663
3	Less: Charity Care	$1,854	$2,500		$2,500	$2,625		$2,625	$2,756		$2,756	$2,894		$2,894
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	**$290,831**	**$303,420**	**$0**	**$303,420**	**$312,938**	**$0**	**$312,938**	**$322,558**	**$0**	**$322,558**	**$332,262**	**$0**	**$332,262**
5	Medicare	$115,320	$124,657		$124,657	$127,442		$127,442	$130,173		$130,173	$132,837		$132,837
6	Medicaid	$55,779	$51,255		$51,255	$51,391		$51,391	$51,470		$51,470	$51,492		$51,492
7	CHAMPUS & TriCare	$257	$264		$264	$268		$268	$271		$271	$274		$274
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$171,356**	**$176,176**	**$0**	**$176,176**	**$179,101**	**$0**	**$179,101**	**$181,914**	**$0**	**$181,914**	**$184,603**	**$0**	**$184,603**
9	Commercial Insurers	$108,375	$115,495		$115,495	$121,554		$121,554	$127,811		$127,811	$134,262		$134,262
10	Uninsured	$709	$727		$727	$736		$736	$744		$744	$751		$751
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$9,139	$9,739		$9,739	$10,250		$10,250	$10,778		$10,778	$11,322		$11,322
13	Other	$1,252	$1,283		$1,283	$1,297		$1,297	$1,311		$1,311	$1,324		$1,324
	Total Non-Government	**$119,475**	**$127,244**	**$0**	**$127,244**	**$133,837**	**$0**	**$133,837**	**$140,644**	**$0**	**$140,644**	**$147,659**	**$0**	**$147,659**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$290,831**	**$303,420**	**$0**	**$303,420**	**$312,938**	**$0**	**$312,938**	**$322,558**	**$0**	**$322,558**	**$332,262**	**$0**	**$332,262**
14	Less: Provision for Bad Debts	$9,675	$9,990		**$9,990**	$10,490		**$10,490**	$11,014		**$11,014**	$11,565		**$11,565**
	Net Patient Service Revenue less provision for bad debts	**$281,156**	**$293,430**	**$0**	**$293,430**	**$302,449**	**$0**	**$302,449**	**$311,544**	**$0**	**$311,544**	**$320,697**	**$0**	**$320,697**
15	Other Operating Revenue	$8,248	$7,253		**$7,253**	$7,253		**$7,253**	$7,253		**$7,253**	$7,253		**$7,253**
17	Net Assets Released from Restrictions	$733	$733		**$733**	$733		**$733**	$733		**$733**	$733		**$733**
	TOTAL OPERATING REVENUE	**$290,137**	**$301,416**	**$0**	**$301,416**	**$310,435**	**$0**	**$310,435**	**$319,530**	**$0**	**$319,530**	**$328,683**	**$0**	**$328,683**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$123,041	$132,928		$132,928	$136,251		$136,251	$139,657		$139,657	$143,149		$143,149
2	Fringe Benefits	$32,244	$30,602		$30,602	$31,367		$31,367	$32,151		$32,151	$32,955		$32,955
3	Physicians Fees	$9,915	$11,031		$11,031	$11,362		$11,362	$11,703		$11,703	$12,054		$12,054
4	Supplies and Drugs	$47,026	$48,991		$48,991	$51,441	($720)	$50,720	$54,013	($1,512)	$52,500	$56,713	($1,588)	$55,125
5	Depreciation and Amortization	$11,502	$11,713		$11,713	$12,064		$12,064	$12,426		$12,426	$12,799		$12,799
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$979	$231		$231	$219		$219	$208		$208	$198		$198
8	Malpractice Insurance Cost	$5,572	$5,917		$5,917	$6,035		$6,035	$6,156		$6,156	$6,279		$6,279
9	Lease Expense				$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,631	$55,648		$55,648	$56,761	($817)	$55,944	$57,896	($1,621)	$56,275	$59,054	($1,654)	$57,401
	TOTAL OPERATING EXPENSES	**$287,910**	**$297,061**	**$0**	**$297,061**	**$305,501**	**($1,538)**	**$303,963**	**$314,211**	**($3,133)**	**$311,078**	**$323,201**	**($3,241)**	**$319,960**
	INCOME/(LOSS) FROM OPERATIONS	**$2,227**	**$4,355**	**$0**	**$4,355**	**$4,934**	**$1,538**	**$6,472**	**$5,319**	**$3,133**	**$8,453**	**$5,482**	**$3,241**	**$8,723**
	NON-OPERATING REVENUE	**$2,190**	**$2,877**		**$2,877**	**$2,963**		**$2,963**	**$3,052**		**$3,052**	**$3,144**		**$3,144**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$4,417**	**$7,232**	**$0**	**$7,232**	**$7,897**	**$1,538**	**$9,435**	**$8,371**	**$3,133**	**$11,505**	**$8,625**	**$3,241**	**$11,867**
	Principal Payments	**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**

NON-PROFIT

Saint Mary's Health System, Inc.

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.8%**	**1.4%**	**0.0%**	**1.4%**	**1.6%**	**0.0%**	**2.1%**	**1.6%**	**0.0%**	**2.6%**	**1.7%**	**0.0%**	**2.6%**
2	Hospital Non Operating Margin	**0.7%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.9%**
3	Hospital Total Margin	**1.5%**	**2.4%**	**0.0%**	**2.4%**	**2.5%**	**0.0%**	**3.0%**	**2.6%**	**0.0%**	**3.6%**	**2.6%**	**0.0%**	**3.6%**
D.	**FTEs**	**1,680**	1,754		**1,754**	1,754		**1,754**	1,754		**1,754**	1,754		**1,754**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	11,847	11,875		**11,875**	11,816		**11,816**	11,757		**11,757**	11,698		**11,698**
2	Outpatient Visits	238,522	246,611		**246,611**	251,543		**251,543**	256,574		**256,574**	261,706		**261,706**
	TOTAL VOLUME	**250,369**	**258,486**	**0**	**258,486**	**263,359**	**0**	**263,359**	**268,331**	**0**	**268,331**	**273,404**	**0**	**273,404**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity: / Description	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$746,752	$786,099		$786,099	$825,404		$825,404	$866,674		$866,674	$910,008		$910,008
2	Less: Allowances	$484,798	$513,815		$513,815	$545,158		$545,158	$578,412		$578,412	$613,695		$613,695
3	Less: Charity Care	$1,854	$1,947		$1,947	$2,044		$2,044	$2,146		$2,146	$2,254		$2,254
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	**$255,868**	**$260,591**	**$0**	**$260,591**	**$268,456**	**$0**	**$268,456**	**$276,370**	**$0**	**$276,370**	**$284,313**	**$0**	**$284,313**
5	Medicare	$101,452	$107,051		$107,051	$110,282		$110,282	$113,533		$113,533	$116,796		$116,796
6	Medicaid	$49,075	$44,014		$44,014	$45,342		$45,342	$46,679		$46,679	$48,020		$48,020
7	CHAMPUS & TriCare	$205	$208		$208	$215		$215	$221		$221	$227		$227
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$150,732**	**$151,273**	**$0**	**$151,273**	**$155,839**	**$0**	**$155,839**	**$160,433**	**$0**	**$160,433**	**$165,044**	**$0**	**$165,044**
9	Commercial Insurers	$95,439	$99,181		$99,181	$102,174		$102,174	$105,186		$105,186	$108,209		$108,209
10	Uninsured	$614	$599		$599	$617		$617	$636		$636	$654		$654
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,034	$8,339		$8,339	$8,591		$8,591	$8,844		$8,844	$9,098		$9,098
13	Other	$1,049	$1,199		$1,199	$1,235		$1,235	$1,271		$1,271	$1,308		$1,308
	Total Non-Government	**$105,136**	**$109,318**	**$0**	**$109,318**	**$112,617**	**$0**	**$112,617**	**$115,937**	**$0**	**$115,937**	**$119,269**	**$0**	**$119,269**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$255,868**	**$260,591**	**$0**	**$260,591**	**$268,456**	**$0**	**$268,456**	**$276,370**	**$0**	**$276,370**	**$284,313**	**$0**	**$284,313**
14	Less: Provision for Bad Debts	$8,180	$8,512		**$8,512**	$8,938		**$8,938**	$9,384		**$9,384**	$9,854		**$9,854**
	Net Patient Service Revenue less provision for bad debts	**$247,688**	**$252,079**	**$0**	**$252,079**	**$259,519**	**$0**	**$259,519**	**$266,985**	**$0**	**$266,985**	**$274,459**	**$0**	**$274,459**
15	Other Operating Revenue	$7,473	$6,267		**$6,267**	$6,267		**$6,267**	$6,267		**$6,267**	$6,267		**$6,267**
17	Net Assets Released from Restrictions	$733	$700		**$700**	$700		**$700**	$700		**$700**	$700		**$700**
	TOTAL OPERATING REVENUE	**$255,894**	**$259,046**	**$0**	**$259,046**	**$266,486**	**$0**	**$266,486**	**$273,952**	**$0**	**$273,952**	**$281,426**	**$0**	**$281,426**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$88,793	$93,086		$93,086	$95,413		$95,413	$97,798		$97,798	$100,243		$100,243
2	Fringe Benefits	$27,562	$25,721		$25,721	$26,364		$26,364	$27,023		$27,023	$27,699		$27,699
3	Physicians Fees	$10,621	$11,268		$11,268	$11,606		$11,606	$11,954		$11,954	$12,313		$12,313
4	Supplies and Drugs	$45,059	$44,320		$44,320	$46,536	($652)	$45,884	$48,863	($1,368)	$47,495	$51,306	($1,437)	$49,869
5	Depreciation and Amortization	$10,805	$11,116		$11,116	$11,449		$11,449	$11,793		$11,793	$12,147		$12,147
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$963	$216		$216	$205		$205	$195		$195	$185		$185
8	Malpractice Insurance Cost	$5,350	$5,094		$5,094	$5,196		$5,196	$5,300		$5,300	$5,406		$5,406
9	Lease Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$48,175		$48,175	$49,139	($708)	$48,431	$50,121	($1,403)	$48,718	$51,124	($1,431)	$49,692
	TOTAL OPERATING EXPENSES	**$238,198**	**$238,996**	**$0**	**$238,996**	**$245,908**	**($1,359)**	**$244,549**	**$253,048**	**($2,772)**	**$250,276**	**$260,422**	**($2,868)**	**$257,554**
	INCOME/(LOSS) FROM OPERATIONS	**$17,696**	**$20,050**	**$0**	**$20,050**	**$20,577**	**$1,359**	**$21,936**	**$20,904**	**$2,772**	**$23,676**	**$21,004**	**$2,868**	**$23,872**
	NON-OPERATING REVENUE	**$3,158**	**$3,716**		**$3,716**	**$3,827**		**$3,827**	**$3,942**		**$3,942**	**$4,061**		**$4,061**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$20,854**	**$23,766**	**$0**	**$23,766**	**$24,405**	**$1,359**	**$25,764**	**$24,847**	**$2,772**	**$27,618**	**$25,064**	**$2,868**	**$27,932**
	Principal Payments	**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**	$3,000		**$3,000**

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**6.8%**	**7.6%**	**0.0%**	**7.6%**	**7.6%**	**0.0%**	**8.1%**	**7.5%**	**0.0%**	**8.5%**	**7.4%**	**0.0%**	**8.4%**
2	Hospital Non Operating Margin	**1.2%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**	**1.4%**	**0.0%**	**1.4%**
3	Hospital Total Margin	**8.1%**	**9.0%**	**0.0%**	**9.0%**	**9.0%**	**0.0%**	**9.5%**	**8.9%**	**0.0%**	**9.9%**	**8.8%**	**0.0%**	**9.8%**
D.	**FTEs**	**1,384**	**1,415**		**1,415**	1,415		**1,415**	1,415		**1,415**	1,415		**1,415**
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	11,847	11,875		**11,875**	11,816		**11,816**	11,757		**11,757**	11,698		**11,698**
2	Outpatient Visits	238,522	246,611		**246,611**	251,543		**251,543**	256,574		**256,574**	261,706		**261,706**
	TOTAL VOLUME	**250,369**	**258,486**	**0**	**258,486**	**263,359**	**0**	**263,359**	**268,331**	**0**	**268,331**	**273,404**	**0**	**273,404**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

SAINT MARY'S HEALTH SYSTEM, INC
($ in thousands)

		Month		Year to Date	
		Sept 2015	Prior Year	Sept 2015	Prior Year
A.	**Operating Performance**				
	Operating Margin	-0.1%	10.0%	0.8%	3.2%
	Non-Operating Margin	-5.0%	4.8%	0.7%	1.4%
	Total Margin	-5.0%	14.9%	1.5%	4.6%
	Bad Debt as % of Gross Revenue	0.7%	1.3%	1.2%	1.5%
B.	**Liquidity**				
	Current Ratio	1.80	2.21	1.80	2.21
	Days Cash on Hand	19	34	19	34
	Days in Net Accounts Receivable	41.72	41.11	41.72	41.11
	Average Payment Period	58	60	58	60
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.29	0.41	0.29	0.41
	Long-term Debt to Capitalization	0.23	0.29	0.23	0.29
	Unrestricted Cash to Debt	1.02	1.26	1.02	1.26
	Times Interest Earned Ratio	-57.7	35.3	5.50	9.94
	Debt Service Coverage Ratio	4.9	15.0	4.90	6.92
	Equity Financing Ratio	4.31	4.42	4.31	4.42
D.	**Additional Statistics**				
	Income from Operations	$ (3)	$ 2,618	$ 2,227	$ 9,146
	Revenue Over/(Under) Expense	$ (1,137)	$ 3,879	$ 4,417	$ 12,830
	EBITDA	$ 1,240	$ 3,756	$ 14,709	$ 21,113
	Patient Cash Collected	$ 21,477	$ 20,756	$ 272,841	$ 258,462
	Cash and Cash Equivalents	$ 14,907	$ 26,867	$ 14,907	$ 26,867
	Net Working Capital	$ 17,591	$ 29,580	$ 17,591	$ 29,580
	Unrestricted Assets	$ 30,950	$ 32,895	$ 30,950	$ 32,895
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Saint Mary's Hospital (Hospital only)	Month		Year to Date	
	Sept 2015	Prior Year	Sept 2015	Prior Year
A. Operating Performance				
Operating Margin	9.0%	15.0%	6.8%	8.2%
Non-Operating Margin	-6.0%	6.0%	1.2%	2.0%
Total Margin	3.0%	21.0%	8.0%	10.2%
Bad Debt as % of Gross Revenue	0.4%	1.1%	1.1%	1.5%
B. Liquidity				
Current Ratio	1.62	2.11	1.62	2.11
Days Cash on Hand	23	40	23	40
Days in Net Accounts Receivable	41.36	41.00	41.36	41.00
Average Payment Period	61	64	61	64
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.32	0.43	0.32	0.43
Long-term Debt to Capitalization	0.24	0.30	0.24	0.30
Unrestricted Cash to Debt	0.97	1.24	0.97	1.24
Times Interest Earned Ratio	30.5	44.9	22.65	18.96
Debt Service Coverage Ratio	11.3	18.0	9.82	10.50
Equity Financing Ratio	4.23	4.00	4.23	4.00
D. Additional Statistics				
Income from Operations	$ 1,820,855	$ 3,421,482	$ 17,685,330	$ 20,208,092
Revenue Over/(Under) Expense	$ 600,798	$ 4,796,952	$ 20,843,189	$ 25,224,814
EBITDA	$ 2,835,133	$ 4,497,195	$ 29,452,841	$ 31,500,487
Patient Cash Collected	$ 18,920,140	$ 17,720,977	$ 239,372,362	$ 229,104,209
Cash and Cash Equivalents	$ 13,310,208	$ 24,610,432	$ 13,310,208	$ 24,610,432
Net Working Capital	$ 7,910,369	$ 21,049,393	$ 7,910,369	$ 21,049,393
Unrestricted Assets	$ 25,882,585	$ 27,668,208	$ 25,882,585	$ 27,668,208
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Exhibit 17
Financial Worksheets

The key assumptions used in Trinity Health- New England, Inc. financial worksheets include the following:

- FY 2015 amounts represent unaudited financial results as of September 30, 2105
- FY 2016 is Trinity Health – New England's revised budget which includes cost reductions as a result of the reduction in the State's supplemental payments.
- Inpatient volume for FY 2016 is projected to be flat with slight decreases in volume in 2017, 2018 and 2019 as a result of decreased utilization of inpatient services as we shift to population health. This overall projected decrease is offset by a slight increase in utilization in the Connecticut Joint Replacement Service line.
- Slight growth in hospital outpatient visits is expected and the projections include increases of .1%, .1% and .2% respectively in 2016 through 2019.
- The projected amounts include an expectation that Saint Francis *Care* will begin to assume risk contracts in FY 2016 and receive per member per month payments to cover the healthcare costs.
- Projected salary expenses include increases of 3.7%, 1.1%, 2.3% and 3.5%, respectively, in 2016 through 2019. This projection anticipates an increase in the number of employees as well as an inflation increase.
- Supplies and other expenses remain flat in FY 2016 and 2017 and slight increases are expected in 2018 and 2019.
- Decrease in interest expense is the result of the restructure of outstanding debt as of October 1 to an intercompany loan with Trinity Health.

The financial projections for FY 2016-2019 do not include potential synergies to be realized as a result of the recent approved transaction between Trinity Health and Trinity Health-New England effective October 1, 2015.

Applicant: Trinity Health - New England, Inc. **NON-PROFIT**

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$ 2,433,797	$ 2,577,924	$ 224,093	$ 2,802,017	$ 2,796,713	$ 917,519	$ 3,714,232	$ 2,992,483	$ 963,395	$ 3,955,878	$ 3,201,957	$ 1,011,565	$ 4,213,522
2	Less: Allowances	1,597,426	1,713,039	144,509	1,857,548	1,919,493	592,210	2,511,703	2,096,555	628,335	2,724,890	2,278,861	666,663	2,945,524
3	Less: Charity Care	14,330	15,761	1,257	17,018	16,076	2,625	18,701	16,398	2,756	19,154	16,726	2,894	19,620
4	Less: Other Deductions	23,689	32,203	225	32,428	32,203	9,746	41,949	32,203	9,746	41,949	32,203	9,746	41,949
	Net Patient Service Revenue	**$ 798,352**	**$ 816,921**	**$ 78,102**	**$ 895,023**	**$ 828,941**	**$ 312,938**	**$ 1,141,879**	**$847,327**	**$ 322,558**	**$ 1,169,885**	**$874,167**	**$ 332,262**	**$1,206,429**
5	Medicare	306,149	304,839	32,217	337,056	323,804	127,442	451,246	328,423	130,173	458,596	331,579	132,837	464,416
6	Medicaid	100,599	83,178	12,973	96,151	86,713	51,391	138,104	87,119	51,470	138,589	87,611	51,492	139,103
7	CHAMPUS & TriCare	1,288	1,087	78	1,165	1,135	268	1,403	1,168	271	1,439	1,181	274	1,455
8	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Government	**$408,036**	**$389,104**	**$45,268**	**$434,372**	**$411,652**	**$179,101**	**$590,753**	**$416,710**	**$181,914**	**$598,624**	**$420,371**	**$184,603**	**$604,974**
9	Commercial Insurers	356,086	397,560	29,757	427,317	391,492	121,554	513,046	405,320	127,811	533,131	429,198	134,262	563,460
10	Uninsured	22,159	17,934	195	18,129	16,141	736	16,877	15,334	744	16,078	14,567	751	15,318
11	Self Pay	-	-		-	-	-	-	-	-	-	-	-	-
12	Workers Compensation	12,071	12,324	2,499	14,823	9,656	10,250	19,906	9,963	10,778	20,741	10,031	11,322	21,353
13	Other	-	-	383	383	-	1,297	1,297	-	1,311	1,311	-	1,324	1,324
	Total Non-Government	**$ 390,316**	**$ 427,818**	**$ 32,834**	**$ 460,652**	**$ 417,289**	**$ 133,837**	**$ 551,126**	**$430,617**	**$ 140,644**	**$ 571,261**	**$453,796**	**$ 147,659**	**$601,455**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 798,352**	**$ 816,922**	**$ 78,102**	**$ 895,024**	**$ 828,941**	**$ 312,938**	**$ 1,141,879**	**$847,327**	**$ 322,558**	**$ 1,169,885**	**$874,167**	**$ 332,262**	**$1,206,429**
14	Less: Provision for Bad Debts	25,600	27,828	2,522	**30,350**	24,220	10,490	**34,710**	$22,817	11,014	**33,831**	$21,200	11,565	**$32,765**
	Net Patient Service Revenue less provision for bad debts	**$ 772,752**	**$ 789,093**	**$ 75,580**	**$ 864,673**	**$ 804,721**	**$ 302,449**	**$ 1,107,170**	**$824,510**	**$ 311,544**	**$ 1,136,054**	**$852,967**	**$ 320,697**	**$1,173,664**
15	Other Operating Revenue	39,526	40,570	1,936	**42,506**	42,000	7,253	**49,253**	43,100	7,253	**50,353**	44,300	7,253	**51,553**
17	Net Assets Released from Restrictions	10,904	10,212	-	**10,212**	9,400	733	**10,133**	9,400	733	**10,133**	9,500	733	**10,233**
	TOTAL OPERATING REVENUE	**$823,182**	**$839,875**	**$77,516**	**$917,391**	**$856,121**	**$310,435**	**$1,166,556**	**$877,010**	**$319,530**	**$1,196,540**	**$906,767**	**$328,683**	**$1,235,450**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$ 378,047	$ 392,253	$ 33,702	$ 425,955	$ 396,501	$ 136,251	$ 532,752	$ 405,935	$ 139,657	$ 545,592	$ 420,297	$ 143,149	$ 563,446
2	Fringe Benefits	86,980	93,031	7,579	100,610	97,757	31,367	129,124	100,722	32,151	132,873	104,543	32,955	137,498
3	Physicians Fees	24,837	25,805	2,900	28,705	26,321	11,362	37,683	26,847	11,703	38,550	27,652	12,054	39,706
4	Supplies and Drugs	128,031	128,006	11,799	139,805	125,387	50,720	176,107	128,259	52,500	180,759	131,465	55,125	186,590
5	Depreciation and Amortization	39,696	39,743	2,919	42,662	42,891	12,064	54,955	45,164	12,426	57,590	47,422	12,799	60,221
6	Provision for Bad Debts-Other[b]	-	-	-	-	-	-	-	-	-	-	-	-	-
7	Interest Expense	11,152	10,950	58	11,008	10,427	219	10,646	10,140	208	10,348	9,861	198	10,059
8	Malpractice Insurance Cost	6,910	12,831	1,479	14,310	13,088	6,035	19,123	13,349	6,156	19,505	13,683	6,279	19,962
9	Lease Expense	9,883	11,084	-	11,084	11,305	-	11,305	11,532	-	11,532	11,820	-	11,820
10	Other Operating Expenses	130,060	123,920	14,180	138,100	119,222	55,944	175,166	118,759	56,275	175,034	121,814	57,401	179,215
	TOTAL OPERATING EXPENSES	**$ 815,596**	**$ 837,623**	**$ 74,616**	**$ 912,239**	**$ 842,899**	**$ 303,963**	**$ 1,146,862**	**$ 860,707**	**$ 311,078**	**$ 1,171,785**	**$888,557**	**$ 319,960**	**$1,208,517**
		$ 350,569	**$ 352,339**			**$ 348,641**			**$ 354,050**			**$ 363,717**		
	INCOME/(LOSS) FROM OPERATIONS	**$ 7,586**	**$ 2,252**	**$ 2,900**	**$ 5,152**	**$ 13,222**	**$ 6,472**	**$ 19,694**	**$ 16,303**	**$ 8,453**	**$ 24,756**	**$18,210**	**$ 8,723**	**$26,933**
	NON-OPERATING REVENUE	(21,308)	-	**652**	**652**	**-**	**2,963**	**2,963**	**-**	**3,052**	**3,052**	**$0**	**3,144**	**$3,144**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (13,722)**	**$ 2,252**	**$ 3,552**	**$ 5,804**	**$ 13,222**	**$ 9,435**	**$ 22,657**	**$ 16,303**	**$ 11,505**	**$ 27,808**	**$18,210**	**$ 11,867**	**$30,077**
	Principal Payments	**$8,785**	**$8,172**	$0	**$8,172**	**$7,673**	$3,000	**$10,673**	**$6,271**	$3,000	**$9,271**	**$6,539**	$3,000	**$9,539**

Applicant: Trinity Health - New England, Inc. **NON-PROFIT**

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.9%	0.3%	3.7%	0.6%	1.5%	2.1%	1.7%	1.9%	2.6%	2.1%	2.0%	2.6%	2.2%
2	Hospital Non Operating Margin	-2.7%	0.0%	0.8%	0.1%	0.0%	0.9%	0.3%	0.0%	0.9%	0.3%	0.0%	0.9%	0.3%
3	Hospital Total Margin	-1.7%	0.3%	4.5%	0.6%	1.5%	3.0%	1.9%	1.9%	3.6%	2.3%	2.0%	3.6%	2.4%
D.	**FTEs**	4,774.7	4,838.0	438.5	5,276.5	4,791.9	1,797.1	6,589.0	4,815.9	1,797.1	6,613.0	4,841.9	1,797.1	6,639.0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	32,337	33,071	2,925	**35,996**	32,316	11,816	**44,132**	32,408	11,757	**44,165**	32,250	11,698	**43,948**
2	Outpatient Visits	1,040,563	1,056,955	64,093	**1,121,048**	1,075,133	251,543	**1,326,676**	1,093,645	256,574	**1,350,219**	1,112,497	261,706	**1,374,203**
	TOTAL VOLUME	**1,072,900**	**1,090,026**	**67,018**	**1,157,044**	**1,107,449**	**263,359**	**1,370,808**	**1,126,053**	**268,331**	**1,394,384**	**1,144,747**	**273,404**	**1,418,151**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Saint Francis Hospital and Medical Center (without affiliates and subsidiaries) **NON-PROFIT**

Applicant:

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$ 2,104,370	$ 2,183,919	$ -	$ 2,183,919	$ 2,336,793	$ -	$ 2,336,793	$ 2,500,369	$ -	$ 2,500,369	$ 2,675,395	$ -	$ 2,675,395
2	Less: Allowances	1,396,910	1,466,182	-	1,466,182	1,601,089	-	1,601,089	1,749,382	-	1,749,382	1,900,716	-	1,900,716
3	Less: Charity Care	13,559	13,796	-	13,796	14,072	-	14,072	14,353	-	14,353	14,640	-	14,640
4	Less: Other Deductions	23,689	32,203	-	32,203	32,203	-	32,203	32,203	-	32,203	32,203	-	32,203
	Net Patient Service Revenue	**$ 670,212**	**$ 671,738**	**$ -**	**$ 671,738**	**$ 689,429**	**$ -**	**$ 689,429**	**$ 704,431**	**$ -**	**$ 704,431**	**$727,836**	**$ -**	**$727,836**
5	Medicare	264,123	255,713	-	255,713	274,505	-	274,505	278,138	-	278,138	280,289	-	280,289
6	Medicaid	83,037	64,842	-	64,842	67,839	-	67,839	67,868	-	67,868	67,976	-	67,976
7	CHAMPUS & TriCare	1,147	909	-	909	945	-	945	974	-	974	982	-	982
8	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Government	**$348,307**	**$321,464**	**$ -**	**$321,464**	**$343,289**	**$ -**	**$343,289**	**$346,980**	**$ -**	**$346,980**	**$349,247**	**$ -**	**$349,247**
9	Commercial Insurers	295,682	323,052	-	323,052	323,108	-	323,108	334,808	-	334,808	356,539	-	356,539
10	Uninsured	15,510	15,280	-	15,280	13,752	-	13,752	13,064	-	13,064	12,411	-	12,411
11	Self Pay	-	-	-	-	-	-	-	-	-	-	-	-	-
12	Workers Compensation	10,713	11,942	-	11,942	9,280	-	9,280	9,579	-	9,579	9,639	-	9,639
13	Other	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Non-Government	**$ 321,905**	**$ 350,274**	**$ -**	**$ 350,274**	**$ 346,140**	**$ -**	**$ 346,140**	**$ 357,451**	**$ -**	**$ 357,451**	**$378,589**	**$ -**	**$378,589**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 670,212**	**$ 671,738**	**$ -**	**$ 671,738**	**$ 689,429**	**$ -**	**$ 689,429**	**$ 704,431**	**$ -**	**$ 704,431**	**$727,836**	**$ -**	**$727,836**
14	Less: Provision for Bad Debts	20,981	23,320	-	**23,320**	20,400	-	**20,400**	19,000	-	**19,000**	17,300	-	**$17,300**
	Net Patient Service Revenue less provision for bad debts	**$ 649,231**	**$ 648,418**	**$ -**	**$ 648,418**	**$ 669,029**	**$ -**	**$ 669,029**	**$ 685,431**	**$ -**	**$ 685,431**	**$710,536**	**$ -**	**$710,536**
15	Other Operating Revenue	31,260	29,397	-	**29,397**	29,985	-	**29,985**	30,585	-	**30,585**	31,197	-	**31,197**
17	Net Assets Released from Restrictions	4,156	3,647	-	**3,647**	3,720	-	**3,720**	3,794	-	**3,794**	3,870	-	**3,870**
	TOTAL OPERATING REVENUE	**$684,647**	**$681,462**	**$0**	**$681,462**	**$702,734**	**$0**	**$702,734**	**$719,810**	**$0**	**$719,810**	**$745,603**	**$0**	**$745,603**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$ 257,621	$ 256,489	$ -	$ 256,489	$ 268,882	$ -	$ 268,882	$ 275,833	$ -	$ 275,833	$ 285,292	$ -	$ 285,292
2	Fringe Benefits	68,083	71,139	-	71,139	78,965	-	78,965	81,344	-	81,344	83,784	-	83,784
3	Physicians Fees	44,673	47,053	-	47,053	47,994	-	47,994	48,954	-	48,954	50,423	-	50,423
4	Supplies and Drugs	106,637	105,873	-	105,873	105,032	-	105,032	107,445	-	107,445	110,132	-	110,132
5	Depreciation and Amortization	37,714	37,700	-	37,700	40,581	-	40,581	42,734	-	42,734	44,871	-	44,871
6	Provision for Bad Debts-Other[b]	-	-	-	-	-	-	-	-	-	-	-	-	-
7	Interest Expense	11,620	10,950	-	10,950	10,427	-	10,427	10,140	-	10,140	9,861	-	9,861
8	Malpractice Insurance Cost	10,303	10,333	-	10,333	10,539	-	10,539	10,750	-	10,750	11,019	-	11,019
9	Lease Expense	7,134	7,047	-	7,047	7,188	-	7,188	7,331	-	7,331	7,515	-	7,515
10	Other Operating Expenses	138,217	135,863	-	135,863	126,592	-	126,592	126,980	-	126,980	130,226	-	130,226
	TOTAL OPERATING EXPENSES	**$ 682,002**	**$ 682,447**	**$ -**	**$ 682,447**	**$ 696,200**	**$ -**	**$ 696,200**	**$ 711,511**	**$ -**	**$ 711,511**	**$733,123**	**$ -**	**$733,123**
	INCOME/(LOSS) FROM OPERATIONS	**$ 2,645**	**$ (985)**	**$ -**	**$ (985)**	**$ 6,534**	**$ -**	**$ 6,534**	**$ 8,299**	**$ -**	**$ 8,299**	**$12,480**	**$ -**	**$12,480**
	NON-OPERATING REVENUE	(20,060)	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**$0**	**-**	**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (17,415)**	**$ (985)**	**$ -**	**$ (985)**	**$ 6,534**	**$ -**	**$ 6,534**	**$ 8,299**	**$ -**	**$ 8,299**	**$12,480**	**$ -**	**$12,480**
	Principal Payments	**$8,785**	**$8,172**	$0	**$8,172**	**$7,673**	$0	**$7,673**	**$6,271**	$0	**$6,271**	**$6,539**	$0	**$6,539**

Applicant: Saint Francis Hospital and Medical Center (without affiliates and subsidiaries) NON-PROFIT

Financial Worksheet (A) Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.4%	-0.1%	0.0%	-0.1%	0.9%	0.0%	0.9%	1.2%	0.0%	1.2%	1.7%	0.0%	1.7%
2	Hospital Non Operating Margin	-3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-2.6%	-0.1%	0.0%	-0.1%	0.9%	0.0%	0.9%	1.2%	0.0%	1.2%	1.7%	0.0%	1.7%
D.	**FTEs**	3,684.8	3,616.7	0.0	3,616.7	3,699.0	0.0	3,699.0	3,702.0	0.0	3,702.0	3,718.0	0.0	3,718.0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	31,632	32,188	-	**32,188**	31,557	-	**31,557**	31,649	-	**31,649**	31,491	-	**31,491**
2	Outpatient Visits	294,633	296,106	0	**296,106**	299,067	0	**299,067**	302,058		**302,058**	305,078	0	**305,078**
	TOTAL VOLUME	**326,265**	**328,294**	**0**	**328,294**	**330,624**	**0**	**330,624**	**333,707**	**0**	**333,707**	**336,569**	**0**	**336,569**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Exhibit 17 Financial Statistics

Trinity Health - New England

Monthly Financial Measurement/Indicators	September 15 YTD	September 14 YTD	September 15 MTD	September 14 MTD	Comments
A. Operating Performance:					
Operating Margin	0.9%	1.3%	(5.5%)	7.8%	operating income/operating revenues
Non-Operating Margin	NA	NA	NA	NA	
Total Margin	7.1%	7.4%	1.0%	13.8%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.1%	1.2%	0.4%	0.8%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio	2.0	2.1	2.0	2.1	current assets/current liabilites
Days Cash on Hand	NA	NA	NA	NA	See SFH for Reported DCOH measurement
Days in Net Accounts Receivables	36.6	40.9	36.6	40.9	net ar/net patient ser rev/days in yr
Average Payment Period	57.9	57.4	57.9	57.4	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity	134.9%	113.9%	134.9%	113.9%	total debt/total equity(net assets)
Long-term Debt to Capitalization	57.4%	53.3%	57.4%	53.3%	LTD/LTD+net assets
Unrestricted Cash to Debt	71.7%	67.2%	71.7%	67.2%	cash =DCOH calc
Times Interest Earned Ratio	1.7	1.9	(2.9)	7.0	EBIT/Interest expense
Debt Service Coverage Ratio	2.9x*	2.7x**	2.9x*	2.7x**	quarter end (use Jun)/ same as SFHMC reported for DSC measurement
Equity Financing Ratio	20.8%	25.2%	20.8%	25.2%	Net assets/total assets
D. Additional Statistics					
Income(Loss) from Operations	7,585,990	10,367,192	(3,651,235)	5,514,737	Net income(loss) from operations
Revenue Over/(Under) Expense	(13,722,368)	12,724,139	(15,314,845)	4,270,976	Net gain(loss)
EBITDA	58,433,786	59,874,237	672,529	9,757,223	based on net income(loss) from operations
Patient Cash Collected	NA	NA	NA	NA	
Cash and Cash Equivalents	102,071,359	93,155,487	102,071,359	93,155,487	from cons bs
Net Working Capital	120,191,181	125,356,264	120,191,181	125,356,264	current assets-current liabilities
Unrestricted Assets	101,674,917	137,311,648	101,674,917	137,311,648	from cons bs

*Measurement data is Sept 30, 2015

**Measurement data is Sept 30,2014

Exhibit 17 Financial Statistics

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Saint Francis Hospital and Medical Center (unaudited)

	September 15 YTD	September 14 YTD	September 15 MTD	September 14 MTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin	0.4%	2.1%	-10.3%	3.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	NA	NA	
Total Margin	7.6%	9.1%	-2.7%	10.1%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.0%	1.1%	0.01%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio	1.9	2.0	1.9	2.0	current assets/current liabilites
Days Cash on Hand	89*	89**	89*	89**	quarter end
Days in Net Accounts Receivables	36.7	39.9	36.7	39.9	net ar/net patient ser rev/days in yr
Average Payment Period	54.4	56.3	54.4	56.3	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity	188.1%	138.4%	188.1%	138.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	65.3%	58.1%	65.3%	58.1%	LTD/LTD+net assets
Unrestricted Cash to Debt	64.0%	60.8%	64.0%	60.8%	as calculated monthly
Times Interest Earned Ratio	1.3	2.2	-4.9	3.1	EBIT/Interest expense
Debt Service Coverage Ratio	2.9x*	2.7x**	3.8x*	2.7x**	quarter end (use jun)
Equity Financing Ratio	17.3%	23.3%	17.3%	23.3%	Net assets/total assets
D. Additional Statistics					
Income(Loss) from Operations	2,884,906	14,421,395	(5,557,203)	1,893,738	Net income(loss) from operations
Revenue Over/(Under) Expense	(17,175,330)	15,620,119	(16,763,738)	1,267,802	Net gain(loss)
EBITDA	51,750,212	61,840,788	(1,433,534)	5,860,101	based on net income(loss) from operations
Patient Cash Collected	NA	NA	NA	NA	
Cash and Cash Equivalents	76,693,459	70,506,821	76,693,459	70,506,821	from cons bs
Net Working Capital	83,760,221	100,331,512	83,760,221	100,331,512	current assets-current liabilities
Unrestricted Assets	52,170,274	100,019,901	52,170,274	100,019,901	from cons bs or rollforward

*Measurement data is Sept 30, 2015

**Measurement data is Sept 30,2014

Saint Francis Hospital and Medical Center

	September 15 YTD	September 14 YTD	
D. Additional Statistics			
Income(Loss) from Operations	2,884,906	14,421,395	Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees.
Revenue Over/(Under) Expense	(17,175,330)	15,620,119	Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($16.8M).
EBITDA	51,750,212	61,840,788	Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees.
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	76,693,459	70,506,821	Decrease in a/r patient ($5.7), Increase in a/p $3.7M. Intercompany paydown of receivable $10M.
Net Working Capital	83,760,221	100,331,512	Decrease in a/r patient ($5.7), Increase in a/p $3.7M.
Unrestricted Assets	52,170,274	100,019,901	Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($17.5M). Pension funding and post retirement liability of ($18M), transfer to affiliate ($14M).

EXHIBIT 18

Saint Mary's
HOSPITAL

Office of the President
Chad W. Wable, FACHE

December 19, 2013

Mr. George C. Jepsen
Attorney General
State of Connecticut
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Re: Response to Request for Information – Disclosure of Facility Fees

Dear Mr. Jepsen:

Enclosed are answers to the questions you sent on November 19, 2013 regarding disclosure of facility fees for off-campus hospital-based providers.

If you have additional questions, please feel free to reach out to me or to Silvia Hutcheson, Director of Strategic Planning and Business Development at Saint Mary's Hospital. Silvia can be reached at (203) 709-3312.

I look forward to working with you further on providing meaningful transparency and cost information to consumers during this time of healthcare transformation.

Sincerely,

Chad W. Wable, FACHE
President and Chief Executive Officer

Enclosures

cc: Robert J. Anthony, Esq., Brown Rudnick, LLC
Silvia Hutcheson, Saint Mary's Hospital
James Iacobellis, Connecticut Hospital Association

Saint Mary's
HOSPITAL

Request for Information: Disclosure of Facility Fees

Submitted by Saint Mary's Hospital
December 19, 2013

1. *Please provide the name, address, specialty type and contact information for each of your off-campus hospital-based providers that currently charges a facility fee.*

Ambulatory Surgery

Name: Saint Mary's Naugatuck Valley Surgical Center
Address: 160 Robbins Street, Waterbury, CT 06708
Specialty: Ambulatory Surgery
Contact Information: The phone number is (203) 755-6663.

Cardiac Testing

Name: Saint Mary's Cardiovascular Diagnostic Center
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Imaging Services (Nuclear Medicine and Carotid Ultrasound) and Cardiac Testing (Echocardiography, Holter Monitoring, and Stress Testing)
Contact Information: The phone number is (203) 709-4506.

Imaging Services

Name: Saint Mary's Medical Imaging Center
Address: 475 Chase Parkway, Waterbury, CT 06708
Specialty: Imaging Services (Outpatient MRI)
Contact Information: The telephone number is (203) 709-5550.

Urgent Care (Two Locations)

First Location
Name: Saint Mary's Naugatuck Urgent Care Center
Address: 799 New Haven Road, Crosspointe Plaza, Naugatuck, CT 06770
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 723-5636.

Second Location
Name: Saint Mary's Wolcott Urgent Care Center
Address: 503 Wolcott Road, Wolcott, CT 06716
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 879-7900.

2. *The name and address of each of your off-campus hospital-based provider(s) that currently <u>does not</u> charge a facility fee. For such provider identified, identify the specialty type and state the reason why the provider does not charge a facility fee.*

Franklin Medical Group, PC, which is an affiliate of Saint Mary's Health System, employs Primary Care and Specialty Care healthcare providers. These healthcare providers do not charge facility fees for services. Services are billed through CPT codes at the physician rate. There are fourteen locations in the community. The locations are listed below:

Location One
Name: Franklin Medical Group
Address: 133 Scovill Street, Waterbury, CT 06706
Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary

Location Two
Name: Franklin Medical Group
Address: 95 Scovill Street, Waterbury, CT 06706
Specialties: Internal Medicine and Pediatrics

Location Three
Name: Franklin Medical Group Behavioral Healthcare Outpatient Services
Address: 100 Jefferson Square, Waterbury, CT 06706
Specialties: Outpatient Behavioral Health Services

Location Four
Name: Franklin Medical Group
Address: 1981 East Main Street, Waterbury, CT 06705
Specialties: Internal Medicine

Location Five
Name: Franklin Medical Group
Address: 202 Water Street, Naugatuck, CT 06770
Specialties: Internal Medicine

Location Six
Name: Franklin Medical Group Primary Care Partners
Address: 166 Waterbury Road, Prospect, CT 06712
Specialty: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery, and Breast Surgery

Location Seven
Name: Franklin Medical Group Wolcott Internal Medicine
Address: 503 Wolcott Road, First Floor, Wolcott, CT 06716
Specialty: Internal Medicine

Location Eight
Name: Franklin Medical Group Breast and Oncology Center
Address: 33 Bullet Hill Road, Suite 214, Southbury, CT 06488
Specialty: General Surgery and Breast Surgery

Location Nine
Name: Franklin Medical Group
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Cardiology, Pulmonary (Sleep Medicine)

Location Ten
Name: Franklin Medical Group
Address: 140 Grandview Avenue, Suite 4, Waterbury, CT 06708
Specialty: Gastroenterology

Location Eleven
Name: Franklin Medical Group
Address: 590 Middlebury Road, Suite A, Middlebury, CT 06762
Specialty: General Surgery

Location Twelve
Name: Franklin Medical Group
Address: 1389 West Main Street, Waterbury, CT 06708
Specialty: General Surgery

Location Thirteen
Name: Franklin Medical Group
Address: 70 Heminway Park Road, Watertown, CT 06795
Specialty: Internal Medicine

Location Fourteen
Name: Franklin Medical Group
Address: 56 Franklin Street, Second Floor, Waterbury, CT 06706
Specialty: Cardiology

Saint Mary's Naugatuck Valley Surgical Center

3. *For **Saint Mary's Naugatuck Valley Surgical Center**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

        Patients receive a packet of information in the mail when surgery is scheduled at least two days in advance of the surgery. The packet includes a Patient Letter, a Patient Handbook as well as forms and questionnaires to complete. The Patient Letter is included as Attachment One, and the Patient Handbook is included as Attachment Two. The Patient Letter states that the Naugatuck Valley Surgical Center is an off-site department and is 100% owned by Saint Mary's Hospital. The Patient Handbook states that as an off-site department of the hospital, the surgery center services are charged at the same rate as the hospital.

    b. *That the provider charges separate professional and facility fees:*

        Patients are informed through the Patient Handbook that separate professional fees and facility fees will be charged.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

        An insurance associate informs patients of their co-payment responsibilities in advance of the surgery. The co-payment is collected prior to surgery.

        Patients who receive services that are not covered by insurance are given a Patient Charge Estimate sheet, which is included as Attachment Three.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

        Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

The Patient Handbook (Attachment Two) directs patients to contact their insurance carrier with questions.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

The Patient Letter (Attachment One) and the Patient Handbook (Attachment Two) are mailed to patients when their surgery is scheduled at least two days in advance.

Patients who are booked just prior to their surgical date receive the Patient Handbook on the day of surgery. These include patients who are booked on the day of their surgery or the day before their surgery.

All patients sign the Authorization for Treatment (Attachment Four) on the day of surgery.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

Patients sign the Authorization for Treatment (Attachment Four), which is hand-delivered, when they arrive for surgery.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

   a. *Signage*

      Signage throughout the surgery center includes the Saint Mary's logo and disclosure of 100% ownership by the hospital. A picture of the signage and ownership disclosure is included as Attachment Five.

   b. *Marketing materials*

      The marketing materials, such as the Patient Handbook (Attachment Two), include the Saint Mary's logo.

   c. *Websites;*

      The website includes the Saint Mary's logo and also states that the ambulatory surgery center is a department of Saint Mary's Hospital. The home page of the Naugatuck Valley Surgical Center website is included as Attachment Eight.

   d. *Stationary; and*

      Stationary, such as the Patient Letter (Attachment One), Discharge Instruction Sheets (Attachment Six), and Prescription Pads (Attachment Seven), include the Saint Mary's Hospital logo.

   e. *Other means of disclosure*

      Business cards of Naugatuck Valley Surgical Center employees include the Saint Mary's logo.

Saint Mary's Cardiovascular Diagnostic Center

3. *For **Saint Mary's Cardiovascular Diagnostic Center**, state whether you require that the provider disclose to patients, in writing:*

a. That the provider is owned, affiliated or part of a joint venture with your hospital:

Patients sign a Cardiovascular Diagnostic Center Billing Form, which is included as Attachment Nine. Patients sign this form prior to receiving services.

b. That the provider charges separate professional and facility fees:

The Cardiovascular Diagnostic Center Billing Form states that the provider charges separate professional and facility fees.

c. The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:

Patients are given estimates only upon request by the patient or family member.

d. An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

e. An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. *That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Cardiovascular Diagnostic Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. *Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

Written notice is not provided when the appointment is scheduled.

b. *Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

Patients sign the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Authorization for Treatment (Attachment Four) on the day of service. Both documents are hand-delivered.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. *Signage*

Signage throughout the Cardiovascular Diagnostic Center includes the Saint Mary's logo. A picture of the Cardiovascular Diagnostic Center signage is included in the brochure, which is Attachment Ten.

b. *Marketing materials*

Marketing materials, such as the Cardiovascular Diagnostic Center Brochure (Attachment Ten), include the Saint Mary's logo.

c. Websites;

The Cardiovascular Diagnostic Center does not have a website at this time.

d. Stationary; and

Stationary, such as the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Appointment Cards (Attachment Eleven), include the Saint Mary's Hospital logo.

e. Other means of disclosure

Not applicable.

Saint Mary's Medical Imaging Center

3. *For **Saint Mary's Medical Imaging Center**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

Patients sign the Authorization for Treatment (Attachment Four). The Saint Mary's Medical Imaging Center does not provide additional written materials about ownership by the hospital.

    b. *That the provider charges separate professional and facility fees:*

The Authorization for Treatment (Attachment Four) states that the provider charges separate professional and facility fees.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

Patients are given estimates only upon request by the patient or family member.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

    f. *A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Saint Mary's Medical Imaging Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

Written notice is not provided when the appointment is scheduled.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

The Authorization for Treatment (Attachment Four) is hand-delivered. Patients sign the Authorization for Treatment on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. Signage

Signage throughout the Medical Imaging Center includes the Saint Mary's logo.

b. Marketing materials

Marketing materials include the Saint Mary's logo.

c. Websites;

The hospital website lists the Saint Mary's Medical Imaging Center as a hospital service. Attachment Twelve includes the Saint Mary's Hospital webpage on Patient Services.

d. Stationary; and

Not applicable.

e. Other means of disclosure

Not applicable.

Saint Mary's Urgent Care Centers

3. *For **Saint Mary's Urgent Care Centers**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

Patients sign two forms when they arrive for service at the Urgent Care Centers. The first form is the Acknowledgement of Disclosure, which is included as Attachment Thirteen. This Acknowledgement of Disclosure states specifically that the center is no longer a "Walk-In" Center (effective November 18, 2012). Patients also sign the Authorization for Treatment (Attachment Four).

    b. *That the provider charges separate professional and facility fees:*

Both forms state that the provider charges separate professional and facility fees.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

Patients are given estimates only upon request by the patient or family member.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Urgent Care Centers do not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?

Appointments for Urgent Care services are not scheduled in advance.

b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?

The forms are hand-delivered. Patients sign the Authorization for Treatment (Attachment Four) and the Acknowledgement of Disclosure (Attachment Thirteen) on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. Signage

Signage throughout the Urgent Care Centers includes the Saint Mary's logo. Attachment Fourteen includes pictures of the signage at the entrance of the Urgent Care Centers.

b. Marketing materials

Marketing materials, such as the yellow banner in the lobbies of the Urgent Care Centers, includes the Saint Mary's logo. A picture of these banners is included as Attachment Fifteen.

c. Websites;

The hospital website (Attachment Twelve) lists the Saint Mary's Urgent Care Centers as a hospital service.

d. Stationary; and

Stationary, such as the letter included as Attachment Sixteen, includes the Saint Mary's logo.

e. Other means of disclosure

A sign, which is included as Attachment Seventeen, is in the registration area of the Urgent Care Centers. This sign is another example of how patients are informed that they will receive separate bills for physician services and facility fees.

Saint Mary's
HOSPITAL

Attachments

Attachment One: Patient Letter

Attachment Two: Patient Handbook

Attachment Three: Patient Charge Estimate

Attachment Four: Authorization for Treatment

Attachment Five: Naugatuck Valley Surgical Center Signage and Ownership Disclosure

Attachment Six: Discharge Instructions

Attachment Seven: Prescription Blanks

Attachment Eight: Naugatuck Valley Surgical Center Website

Attachment Nine: Cardiovascular Diagnostic Center Billing Form

Attachment Ten: Saint Mary's Cardiovascular Diagnostic Center Brochure

Attachment Eleven: Saint Mary's Cardiovascular Diagnostic Center Appointment Card

Attachment Twelve: Saint Mary's Hospital Website on Patient Services

Attachment Thirteen: Acknowledgement of Disclosure

Attachment Fourteen: Urgent Care Center Signage

Attachment Fifteen: Urgent Care Center Banner

Attachment Sixteen: Urgent Care Center Letter

Attachment Seventeen: Urgent Care Center Sign in Registration Area

NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

Dear Patient, Parent or Guardian:

The Naugatuck Valley Surgical Center is dedicated to providing exceptional patient quality care. To assist in obtaining all of the important information we need to know about you, please **completely** fill out the enclosed **"Patient Data Form", "Health Questionnaire" and "Medication Reconciliation"** sheet.

Please return the completed forms in the enclosed envelope as soon as possible, or Fax to 203-756-9645.

***If your procedure is within 3 days of the receipt of these forms, please fax or bring the completed forms with you on the day of your procedure.

Preparing for your surgery can make the day of surgery less stressful. A nurse from the surgical center will call you prior to your surgery to review your medical history, notify you of the time of your surgery and give you instructions. Depending on your health history, you may be required to have pre-admission testing performed. You will also be required to have someone drive you home and stay with you for 24 hours after the procedure. **IF YOU WILL NOT BE HOME TO RECEIVE THIS CALL, PLEASE CONTACT THE SURGICAL CENTER BEFORE NOON THE DAY BEFORE YOUR PROCEDURE.** Also, if at any time prior to your surgery you become ill or have any new health problems, please contact your physician and the Surgical Center. Changes in your health may impact your physician's decision to perform your procedure.

INSURANCE CARDS: Please bring your insurance cards with you on the day of the surgery. We will also need to copy your driver's license or picture identification.

INSURANCE CO-PAYS: You will be responsible for any **"Hospital One Day Surgery"** co-pay required by your insurance company. This is due on the day of the surgery. We will submit all of your NVSC facility charges to your insurance carrier. If there is an outstanding balance, the billing department will send a statement with your balance due. They are also available to set up payment arrangements prior to your procedure. For your convenience, we accept cash, credit cards, debit cards and personal or bank checks. If you elect to place a credit card on file, charges will be applied for the balance due.

PRE-AUTHORIZATION: If your insurance company requires pre-authorization, please make sure that your physician takes care of this prior to your procedure.

PATIENT BILL OF RIGHTS & RESPONSIBILITIES A copy of the "Patient Bill of Rights and Responsibilities" are included with information on "Your Rights to Make Health Care Decisions".

OWNERSHIP: The Naugatuck Valley Surgical Center is an off site department and 100% owned by Saint Mary's Hospital.

If you have any questions about the information provided or requested, please contact us at (203) 755-6663

160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663 • FAX (203) 756-9645

Directions

From the North:
Take Route 8 South to Exit 33 (Interstate 84 West) and follow directions below.

From the South:
Take Route 8 north to Exit 33 (Interstate 84 West) and follow directions below.

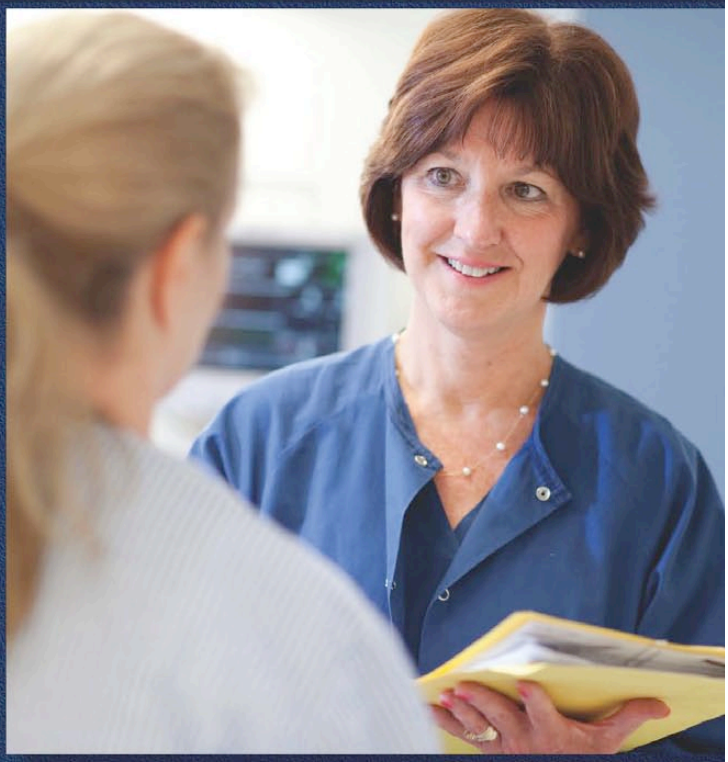
From the East:
Take Interstate 84 West to Exit 18. Bear left on the exit ramp for West Main Street. At the end of the exit ramp, turn right onto West Main Street. After the first light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

From the West:
Take Interstate 84 East to Exit 18 (Chase Parkway). At the end of the exit ramp, turn right onto Chase Parkway. Proceed to light, turn right and cross over the highway. At the next light, turn right onto West Main Street. After the second light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

160 Robbins Street
Waterbury, CT 06708
(203) 755-6663
nvsc.org
info@nvsc.org



Patient Handbook

What you need to know before surgery

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

Welcome

Betty Bozzuto
Vice President
Surgical Services

Welcome to the Naugatuck Valley Surgical Center. As a department of Saint Mary's Hospital, we are committed to providing exceptional care to every patient, every day.

Your surgeon has chosen our surgical center for our skill and our reputation of delivering high quality and individualized care to this community since 1986. Here, your surgeon works with highly qualified anesthesiologists, CRNAs, registered nurses and support staff in a facility equipped with state-of-the-art technology. Our surgical center staff is experienced in gynecology, ophthalmology, orthopedics, gastroenterology, podiatry, otorhinolaryngology (ENT), urology, oral/dental surgery, general surgery, plastic surgery and pain management.

You may be interested to know that over 70% of all surgery is now performed in an outpatient surgical setting similar to this one.

You can expect personalized care – because you are important to us.

During your stay, you can expect:

- A facility designed exclusively for and specializing in ambulatory surgery
- State-of-the-art operating rooms and post-operative patient care areas
- Individualized, high-quality care given in a warm, friendly setting
- Staff that is fully CPR, ACLS and PALS certified
- Thorough medical staff credentialing and Medical Advisory Board physician peer review
- Licensure by the State and Medicare Certification
- Cost-effective services with the same charge structure as Saint Mary's Hospital

Insurance & Billing

We participate with most local and national insurers, HMOs, PPOs, IPAs and Workers' Compensation carriers. We also participate with Medicare and most Medicaid programs.

For the services rendered at the time of your visit, your insurance company will be billed with the information that you provide for us. As an off-site department of Saint Mary's Hospital, our charges are the same as services at the hospital.

If you have any questions as to whether the Center participates with your insurance carrier, please contact our billing department or your insurance carrier. You are responsible for any deductibles, co-insurance or one day surgery co-pays. Co-pays are due at the time of your visit.

Dental surgery is paid with your hospital insurance, not your dental insurance. Check your coverage with your insurance carrier or employer.

You will receive a bill from Saint Mary's Hospital/ Naugatuck Valley Surgical Center for any balance that is billable to you after your insurance is paid. You will also receive a separate bill from your surgeon, anesthesiologist, pathology and/or radiology departments, depending on which services were utilized when you were a patient at our center.

Patients having non-covered or cosmetic procedures, or uninsured patients, are asked to settle their account before surgery is performed. Our Billing Associate will contact you with an estimate of charges for the procedure that your surgeon has scheduled for you. All charges are estimated and may differ from the estimate if additional or different procedures are performed. The patient is responsible for any additional charges that result. Any unpaid balance will be billed to you, and payment is requested within 30 days of receipt of statement.

Workers' Compensation

Workers' Compensation claims need additional information. Please make sure that you provide the following information on the "Patient Data" form: Workers' Compensation insurance carrier name and contact person, employer name and address, date and time of injury, and claim number.

Your Child & Surgery

As you might expect, surgery is often frightening to your child, mostly because the surroundings and the experience are unfamiliar. The Surgical Center staff will work with parents to reassure your child and make him/her feel at ease. All questions are important to us, and we encourage you to let us know of any concerns. We care.

Here is how we can help:

- Call us as soon as surgery is scheduled ***to arrange a personal tour*** for you and your child, if you so desire.
- ***A Surgical Center nurse will call before the day of surgery*** to confirm specific instructions about your child's operation. If you will not be available by phone, please call us the day before surgery, between 8:00 a.m. and 2:00 p.m.
- ***We will not leave your child alone***, not even for a minute. From admitting to recovery, our qualified staff will attend to your child's needs.

This is how you can help:

- ***Tell your child what to expect.*** Encourage him or her to ask questions. We are happy to discuss any questions your child may have at the time of your tour.
- ***Stay with your child.*** We recognize that a parent's presence is very comforting to a child. You may stay with your child until he/she is taken into the operating room. You will be reunited almost immediately following surgery.
- ***Bring your child's favorite blanket, toy or book.***
- ***Accompany your child under 18 years of age.*** A parent or guardian must remain at the Surgical Center while your child is in our facility. Parents and guardians must sign all consent forms for children under 18.

Before Surgery

Before surgery, ***call your surgeon*** if you have questions or if there is any change in your physical condition. You should call even if you just have a scratchy throat.

Ask about medication. If you take aspirin, medication containing aspirin, diet pills, blood thinners, or herbal supplements on a regular basis, please ask your doctor if and when you should stop taking them prior to your surgery. We may also give you instructions about medications.

You can expect a call before the day of surgery. A Surgical Center nurse will call you to confirm the time of your surgery, review your medical history and give you pre-operative instructions. These instructions are for your benefit, safety and comfort. If you are not available by phone, please call us the day before your surgery, between 8:00 a.m. and 4:00 p.m.

Each patient must have a history and physical form completed within 30 days of surgery. Ask your surgeon if he/she will complete the form, or see your medical doctor. Your surgeon will determine if any lab work is required prior to surgery.

Do not eat or drink anything — not even gum, hard candy or a glass of water — after midnight the night before your procedure, unless otherwise advised by the Surgical Center. Also, children may receive different instructions.

Arrange for a ride home. A responsible person must accompany you home. *You will not be permitted to drive yourself home.*

Please follow the rules for your safety and comfort. If you do not follow these rules, and the rules listed for the day of surgery, we may have to cancel your surgery for safety reasons.

Day of Surgery

Remember to follow these rules; they are designed for your safety, comfort, and convenience.

Arrive one hour and 15 minutes before your scheduled operation, unless directed otherwise. When you arrive, you will meet your anesthesiologist to discuss the best anesthetic for your surgery. You will also meet your nurses and other members of our staff who will be glad to assist you during your stay.

Do not eat or drink, including water, in the morning, unless otherwise advised by the Surgical Center.

Wear loose-fitting casual clothing that you can store in a locked drawer. We will provide a patient gown, bathrobe, and slippers for your surgery.

Please leave contact lenses at home. If you must bring them, bring a storage case and solution.

All body piercings should be removed.

Please leave all jewelry and valuables at home.

Do not wear makeup or fingernail polish.

Toenail polish should be removed if you are having any foot, knee or other leg surgery.

Bring your completed Patient Data Form, Health Questionaire, Medication Reconciliation and insurance forms if you have not already mailed them to us.

Bring your insurance ID card(s) and a photo ID.

Following Surgery

After your surgery, you will awaken in the comfortable atmosphere of the Post Anesthesia Care Unit (Recovery Room), where our professional staff will continue to monitor your recovery. Your nurse will encourage you to drink liquids and provide you with a large dose of personal attention.

When your anesthesiologist determines that you're ready to go home, your nurse will review your home care instructions with you and your family.

You may not drive yourself home. Someone must drive you home, as you may feel slightly sleepy or dizzy after anesthesia and medications.

The next 24 hours are important to your recovery. Even though surgery is behind you, you still need to allow time to recover at home.

Here is what you must do at home:

- ***Have a responsible adult with you and someone to stay home with you for the first 24 hours.***
- ***Do not drive or operate heavy equipment.***
- ***Follow the special instructions that your surgeon or our staff provided.***
- ***Do not take medications without your surgeon's approval.***
- ***Call your surgeon if you have unusual symptoms or changes in your condition that you were not expecting.***
- ***Do not drink any alcoholic beverages.***
- ***Expect to hear from us.*** Your Post Anesthesia Care Unit nurse will call the day after surgery to check your progress and answer any questions.
- ***Pamper yourself*** and avoid strenuous activity. Do not be fooled; you may feel fine immediately following surgery, but this is not the day to overdo it!
- ***Do not sign any legal documents.***

You may also receive a patient questionnaire following surgery. Please fill this form out and return it to us — your response and input means a lot to us.

Saint Mary's HOSPITAL

Patient Charge Estimate

for: pt

PATIENT NAME: _____
PATIENT PHONE: _____

PLANNED DOS:_____

PHYSICIAN NAME: _____
PHYSCIAN PHONE: _____

INSURANCE CO: _____
INSURANCE PHONE: _____

BENEFIT INFO: _____
_____
_____
_____
_____

PROPOSED PROCEDURE:
CPT CODE:_____ **FEE:**_____
CPT CODE:_____ **FEE:**_____
CPT CODE:_____ **FEE:**_____
ANESTHESIA FEE: _____ **FEE:**_____

NOTES: This estimate is based on the attached booking. This quote is subject to change if the physician changes the procedure.

_____
_____
_____

_____
pt signature **date**

Disclaimer

This is an estimate of charges for hospital services only. It is a good faith estimate based on the hospital's current price list, an average of previous procedures performed at Saint Mary's Hospital, and the treatment your physician is ordering for you. It is not legally binding. Your final bill may be more or less than this estimate. If you have overpaid us, we will promptly refund you. If you have not paid us enough, we expect additional payment from you.

Denegación

El siguiente es un estimado solo por servicios proveidos por el hospital. Es un estimado en buena fe basado en la lista de precios del hospital, un promedio del costo de procedimientos previos del hospital, y de el tratamiento ordenado por su medico. Su cuenta final puede ser mas o menos que la dicha en este estimado. En caso de un sobre pago al hospital, le reembolsaremos el sobrante. En caso de un corto pago, esperamos su saldo inmediato.

AUTHORIZATION FOR TREATMENT

I hereby give my consent to the hospitalization and treatment at Saint Mary's Hospital, which adheres to the Catholic Ethical and Religious Directives, encompassing routine Diagnostic testing and/or procedures which may include HIV-related tests, Medical and/or Surgical treatment and whatever Anesthesia deemed necessary by my (His, Her) Physician, His/Her Assistant or Designates. Upon presentation for outpatient services I acknowledge that I am under the care of the referring physician.

AUTHORIZATION TO RELEASE INFORMATION FOR SUBSEQUENT CARE

The undersigned hereby authorizes Saint Mary's Hospital to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary for referral to any medical practitioner and/or medical facility responsible for my subsequent care.

DISCLOSURE OF INFORMATION FOR PAYMENT

The undersigned hereby authorizes Saint Mary's Hospital and/or hospital based physicians to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF INSURANCE BENEFITS

I agree to pay all charges for services rendered to me between admission and discharge and/or all charges for ambulatory care or outpatient services. I hereby assign payment directly to Saint Mary's Hospital, 56 Franklin Street, Waterbury CT 06706 and/or hospital based physicians of the health insurance benefits otherwise payable to me but not to exceed the regular charges for this period of hospitalization and/or outpatient treatment. I understand that I will be responsible for charges not covered by my health insurance plan, which may include but is not limited to all co- payments, deductibles and non-covered services such as cosmetic surgery. I further agree that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed to Saint Mary's Hospital and/or hospital based physicians by myself or my family. If I am uninsured or otherwise unable to pay my medical bill, I understand that I can request to speak with a financial counselor to determine my eligibility for available financial assistance. **Please note: If you receive care from physician independent contractors and/or hospital based physicians such as anesthesiologists, radiologists, pathologists, or other physicians, you will receive a separate bill directly from them in addition to a hospital facility bill.**

SERVICES PROVIDED BY INDEPENDENT CONTRACTORS

I acknowledge and understand that the Anesthesia, Emergency, Radiology and Pathology services that I may receive at Saint Mary's Hospital will be provided by physicians who are self-employed, independent contractors. Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians, and they are not agents, servants, or employees of Saint Mary's Hospital. I also acknowledge that private attending physicians, and the consultants to whom they may refer my care and treatment, are also not agents, servants or employees of Saint Mary's Hospital, and Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians.

PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE) _____ DATE AND TIME _____ RELATIONSHIP _____

PATIENT UNABLE TO SIGN (INDICATE REASON) _____

WITNESSED BY _____ DATE AND TIME _____

NOTE: Parental consent required for unemancipated minors.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Saint Mary's Hospital Notice of Privacy Practices. The Notice describes how my health may be used or disclosed. I understand that I should read it carefully.

DATE _____ PRINT NAME _____ SIGNATURE _____

As the representative of the above patient, I acknowledge receipt of the Notice on his or her behalf.

DATE _____ PRINT NAME _____ SIGNATURE _____

FOR HOSPITAL USE ONLY* ☐Patient and family unable to sign ☐Patient refused to sign ☐Emergent Care Required

(Document comments) _____

_____ Signature / Date: _____

Saint Mary's HOSPITAL

56 Franklin Street, Waterbury, CT 06706

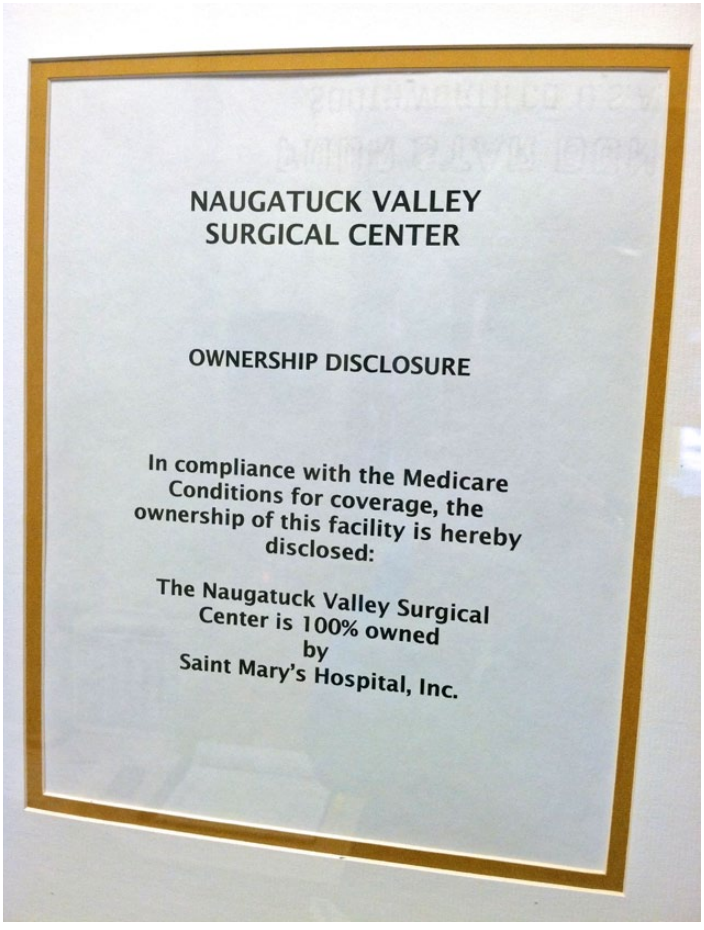
AUTHORIZATION FOR TREATMENT

Place Patient Label Above This Line

5313L

5313L R 11/14/12

NAUGATUCK VALLEY
SURGICAL CENTER
Saint Mary's Hospital


NAUGATUCK VALLEY
SURGICAL CENTER
OWNERSHIP DISCLOSURE
In compliance with the Medicare Conditions for coverage, the ownership of this facility is hereby disclosed:
The Naugatuck Valley Surgical Center is 100% owned by
Saint Mary's Hospital, Inc.

NAUGATUCK
VALLEY
SURGICAL
CENTER
Saint Mary's Hospital
ENTRANCE
HOURS OF OPERATION
Mon.-Fri. 6:30 a.m. to 5:00 p.m.
Closed Saturday and Sunday
In the event of an
AFTER HOUR EMERGENCY
Go to the nearest Hospital
Or call 911 for help

OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME

Activity

- Everyone reacts differently to anesthesia - You may experience dizziness or sleepiness afterwards. A **RESPONSIBLE ADULT** must be with you for **24 Hours** after surgery.
- Rest at home for 24 hours after general anesthesia or local anesthesia with sedation.
- **Do Not Drive** or operate machinery for 24 hours or as instructed by your physician.
- ☐ You may shower after _____ hours, or ☐ sponge bathe only.

Medications

- Take your prescriptions as ordered. If antibiotics are prescribed, finish the entire prescription. If you experience anything unusual such as a rash, nausea, or vomiting, notify your physician immediately. If your pain medication is not effective, notify your physician.
- Avoid driving, operating machinery or drinking alcohol when using pain medication.
- If you take daily Aspirin or blood thinners, resume per your physicians instructions.

Diet

- Avoid alcohol for 24 hours after anesthesia.
- Eat light foods that are very easy to digest and progress to a regular diet as tolerated, unless otherwise specified by your physician.

Wound Care

- Keep your dressing clean and dry. Do not remove dressing unless instructed to do so.
- Apply ice to _____ for _____ .
- Elevate _____ as instructed.
- Notify your physician regarding excessive bleeding, swelling or pain, fever greater than 101°, any unusual color changes or temperature changes to the operative extremity or if your dressing feels too tight. After surgical dressings are removed any redness, swelling or foul drainage from incision should be reported.

Special Instructions: _____

_____

_____

IF ANY PROBLEMS OCCUR, CONTACT YOUR SURGEON. A NURSE WILL CALL THE NEXT BUSINESS DAY.
IF YOU HAD YOUR SURGERY AT THE SURGICAL CENTER, YOU CAN CALL THEM BEFORE 4:30.
KEEP THESE INSTRUCTIONS BY THE PHONE SO YOU CAN REFER TO THEM.

IN THE EVENT OF AN EMERGENCY PLEASE CALL 911 OR GO TO THE EMERGENCY ROOM.

Thank You for choosing Saint Mary's Hospital.

Surgeon Telephone # _____ Follow up appointment _____

☐ Discharge patient when discharge criteria met.

TO/VO BY M.D. TAKEN BY R.N.			I have participated in the development and understand the Discharge Plan. SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:	TIME AM PM DATE / /	
SIGNATURE AND DATE	HOUSE STAFF SIGNATURE	TIME AM PM DATE / /	NURSING SIGNATURE	TIME AM PM DATE / /	
			ATTENDING SIGNATURE M.D.	TIME AM PM DATE / /	

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

NVSC NAUGATUCK VALLEY SURGICAL CENTER
160 Robbins Street
Waterbury, CT 06708

OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME

MUST BE COMPLETED PRIOR TO DISCHARGE

7493

Place Patient Label Above This Line

WHITE - MEDICAL RECORDS YELLOW - PATIENT 7493 R 4/23/12

NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

No. 5928

160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663

Name _____ Age _____

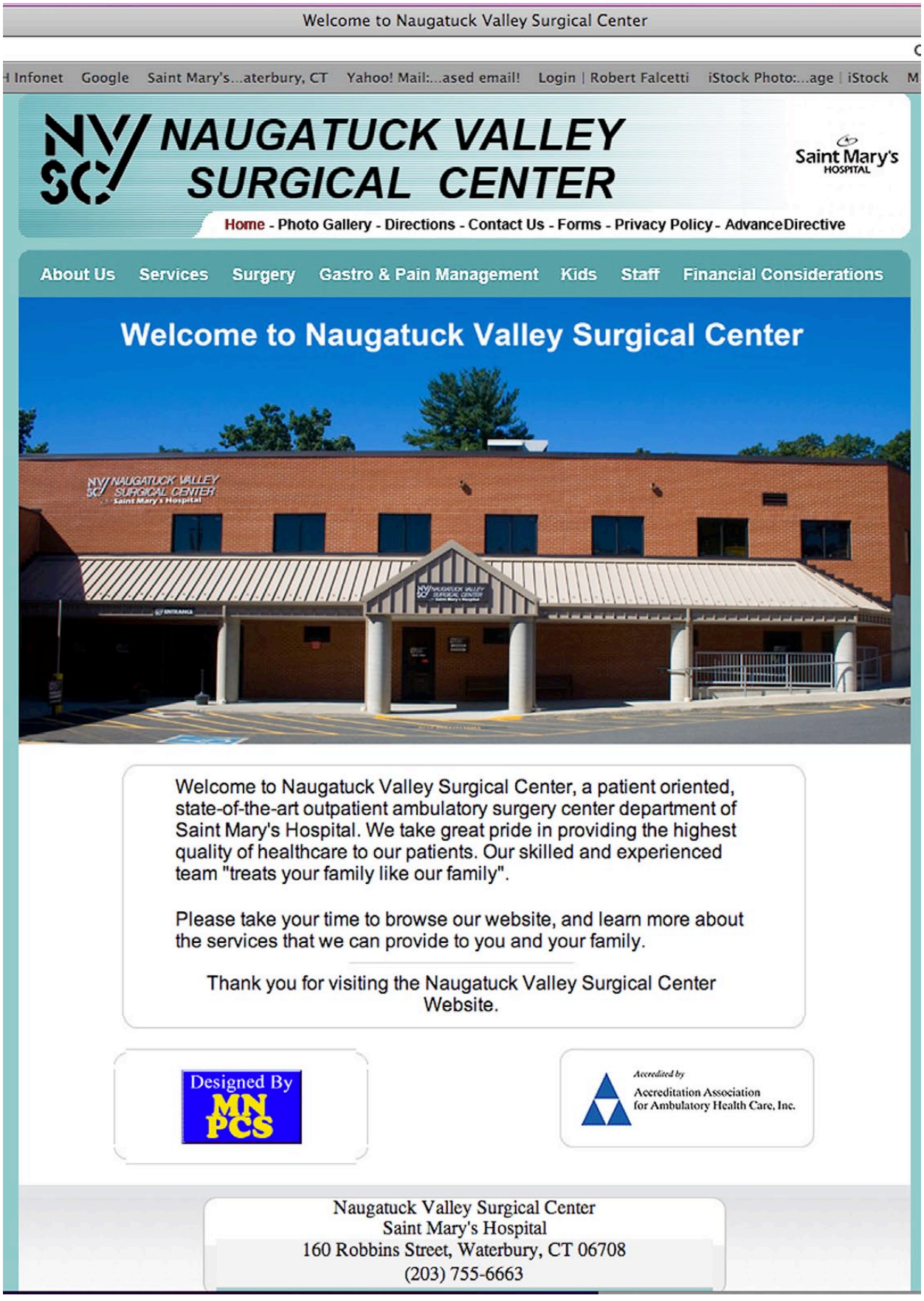
Address _____ Date _____

℞

☐ 1 -24 ☐ 25 - 49 ☐ 50 - 74 ☐ 75 - 100 ☐ 101 - 150 ☐ 150+

_____, M.D.

Refill amounts_____ D.E.A. # _____


Welcome to Naugatuck Valley Surgical Center
Infonet
Google
Saint Mary's...aterbury, CT
Yahoo! Mail:...ased email!
Login | Robert Falcetti
iStock Photo:...age | iStock
NAUGATUCK VALLEY SURGICAL CENTER
Saint Mary's HOSPITAL
Home - Photo Gallery - Directions - Contact Us - Forms - Privacy Policy - AdvanceDirective
About Us
Services
Surgery
Gastro & Pain Management
Kids
Staff
Financial Considerations
Welcome to Naugatuck Valley Surgical Center
Welcome to Naugatuck Valley Surgical Center, a patient oriented, state-of-the-art outpatient ambulatory surgery center department of Saint Mary's Hospital. We take great pride in providing the highest quality of healthcare to our patients. Our skilled and experienced team "treats your family like our family".
Please take your time to browse our website, and learn more about the services that we can provide to you and your family.
Thank you for visiting the Naugatuck Valley Surgical Center Website.
Designed By MN PCS
Accredited by
Accreditation Association for Ambulatory Health Care, Inc.
Naugatuck Valley Surgical Center
Saint Mary's Hospital
160 Robbins Street, Waterbury, CT 06708
(203) 755-6663

CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM

Thank you for choosing Saint Mary's Cardiovascular Diagnostic Center.

Here is some important information about how we bill for tests that are performed at the Cardiovascular Diagnostic Center.

I understand that I and/or my insurance provider will receive two bills.

- **One bill is for the professional services of the physician interpreting your test. Saint Mary's Hospital has partnered with Franklin Medical group to provide these professional services. If I have any question regarding the FMG bill, I can call 1-800-925-7270.**

- **The other bill is for the technical services, equipment and supplies provided by Saint Mary's Hospital personnel performing the test. The Cardiovascular Diagnostic Center is an outpatient department of Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital's bill, I can call 203-709-6428.**

Date: _____ Signature: _____ Relationship: _____

Date: _____ Witnessed by: _____

❑ PATIENT UNABLE TO SIGN _____
(INDICATE REASON)

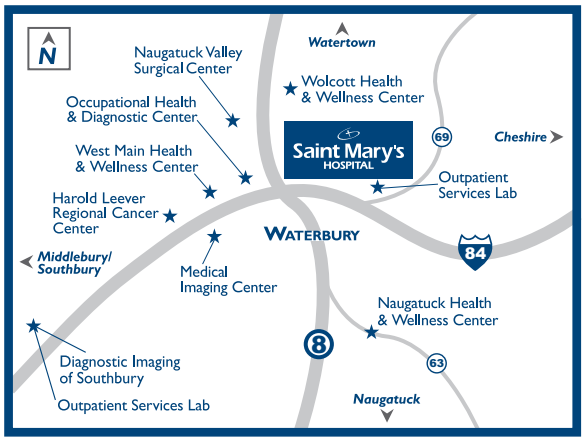
Date: _____ Witnessed by: _____

Date: _____ Witnessed by: _____

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM

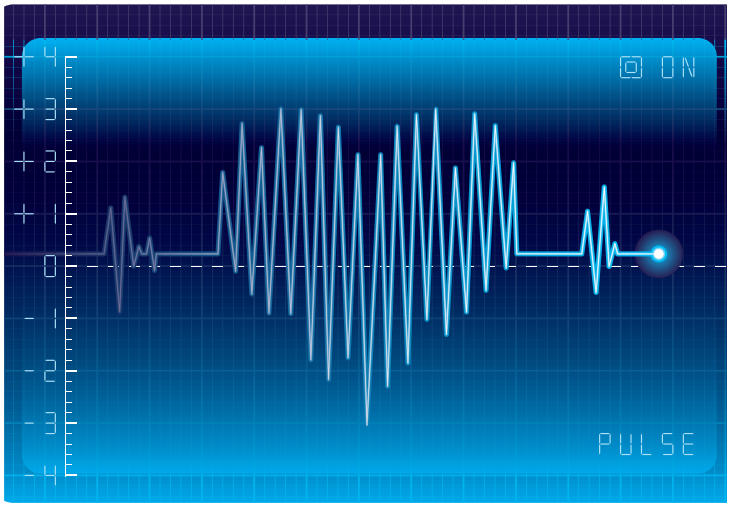
Saint Mary's Health System offers a range of convenient, quality services for patients close to home through its network of health and wellness centers.



Our center is located directly off I-84 in Waterbury with ample free parking and easy, first-floor access. Come visit us at:

1320 West Main Street
Waterbury

For appointments, call (203) 709-4506.



Saint Mary's Cardiovascular Diagnostic Center

When it comes to cardiac testing, we don't miss a beat

Saint Mary's HEALTH SYSTEM
Exceptional care. Every patient. Every day.
stmh.org

6679

Saint Mary's HEALTH SYSTEM
Exceptional care. Every patient. Every day.

Integrated Cardiac Care

at Saint Mary's Cardiovascular Diagnostic Center

The Saint Mary's Hospital Cardiovascular Diagnostic Center features state-of-the-art technology and a caring, experienced staff. As an added advantage for patients, the center is located adjacent to Franklin Medical Group Cardiology, the practice of Dr. Paul Kelly, Dr. Peter Chien, and Mary Kokoska, APRN.

The Cardiovascular Diagnostic Center offers a full range of cardiac testing services. Our highly-skilled and experienced cardiac specialists are dedicated to providing exceptional care for patients who require diagnostic testing.

Our services include:

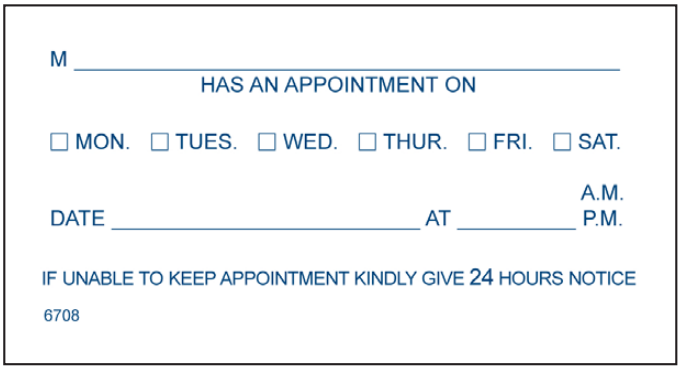
- Stress testing with nuclear imaging
- Echocardiography
- Vascular ultrasound
- Phlebotomy
- Coumadin clinic
- Arrhythmia monitoring
- Routine maintenance and monitoring of defibrillators and pacemakers

In most cases, test results are shared with referring physicians the same day. For appointments, please call **(203) 709-4506.**

Front

Saint Mary's
Cardiovascular Diagnostic Center
1320 West Main Street, Waterbury, Connecticut 06708
PHONE: 203-709-4506
FAX: 203-709-4566
www.stmh.org
A service of Saint Mary's Health System

Back


M _____
HAS AN APPOINTMENT ON
☐ MON. ☐ TUES. ☐ WED. ☐ THUR. ☐ FRI. ☐ SAT.
DATE _____ AT _____ A.M. P.M.
IF UNABLE TO KEEP APPOINTMENT KINDLY GIVE 24 HOURS NOTICE
6708

Saint Mary's Hospital, Waterbury, CT – Patient Services
Google
Popular
SMH Infonet
Google
Saint Mary's...aterbury, CT
Yahoo! Mail:...ased email!
Login | Robert Falcetti
iStock Photo:...age | iStock
MapQuest M...ion
Saint Mary's
HEALTH SYSTEM
Exceptional care. Every patient. Every day.
Home
Site Map
Contact Us
Directions
News
Portals
About Saint Mary's
Patient Services
Admission Information
Physician Services
Graduate Medical Ed.
Foundation - Ways to Give
Career Portal
Special Events
Affiliate Companies
Community Programs
Portals
Patient Services
Behavioral Health Care Services
Cardiac Care
Emergency Medical Services
Community Training Center
EMS Services Provided
Endoscopy Department
Level II Trauma
Lifeline
Medical Imaging Center
Occupational Health
Pulmonary Rehabilitation
Saint Mary's Urgent Care Centers
Sleep Disorders Center
Surgical Weight Control
Women and Children Services
The Birthplace
Children and Family Services
Growing Family Web Nursery
Maternity Pre-Admission Form
Pediatrics
Wound Healing Center
Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
(203) 709-6000

Acknowledgment of Disclosure

Saint Mary's Hospital would like to thank you for patronizing our Urgent Care Facility. We are committed to providing you and your family the best medical care possible. We ask that you read over the following information, initial the boxes and sign your name at the bottom of the page. If you should have any questions, please ask our front desk staff for assistance.

_____ I understand that the Saint Mary's Urgent Care Center is no longer a designated Walk-in Center effective November 18, 2012, and as a result of that change the level of services available has increased.

Urgent Care is the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment. As an Urgent Care Center, we can treat many problems that can be seen in a primary care physician's office, but we offer some services that are generally not available in a primary care physician's office, such as, X-Ray's, treatment of minor fractures, foreign body removal and repair of minor and moderate-severity lacerations.

_____ I understand that the physicians are not employed by Saint Mary's Hospital and that fees charged by these physicians for services provided will be billed separately and apart from the fees charged by the hospital.

_____ I understand that the physician's services will be billed by Long River Physicians.

_____ **Insured Patients:** I understand that the services being provided will be submitted to my insurance carrier as an Urgent Care charge I also understand that some insurance carriers may process this claim as an Emergency Visit and assess an Emergency Room Co-pay/Deductible.

Patient/Guarantor Signature:_____Date:_____

UCC Employee Signature: _____Extension _____

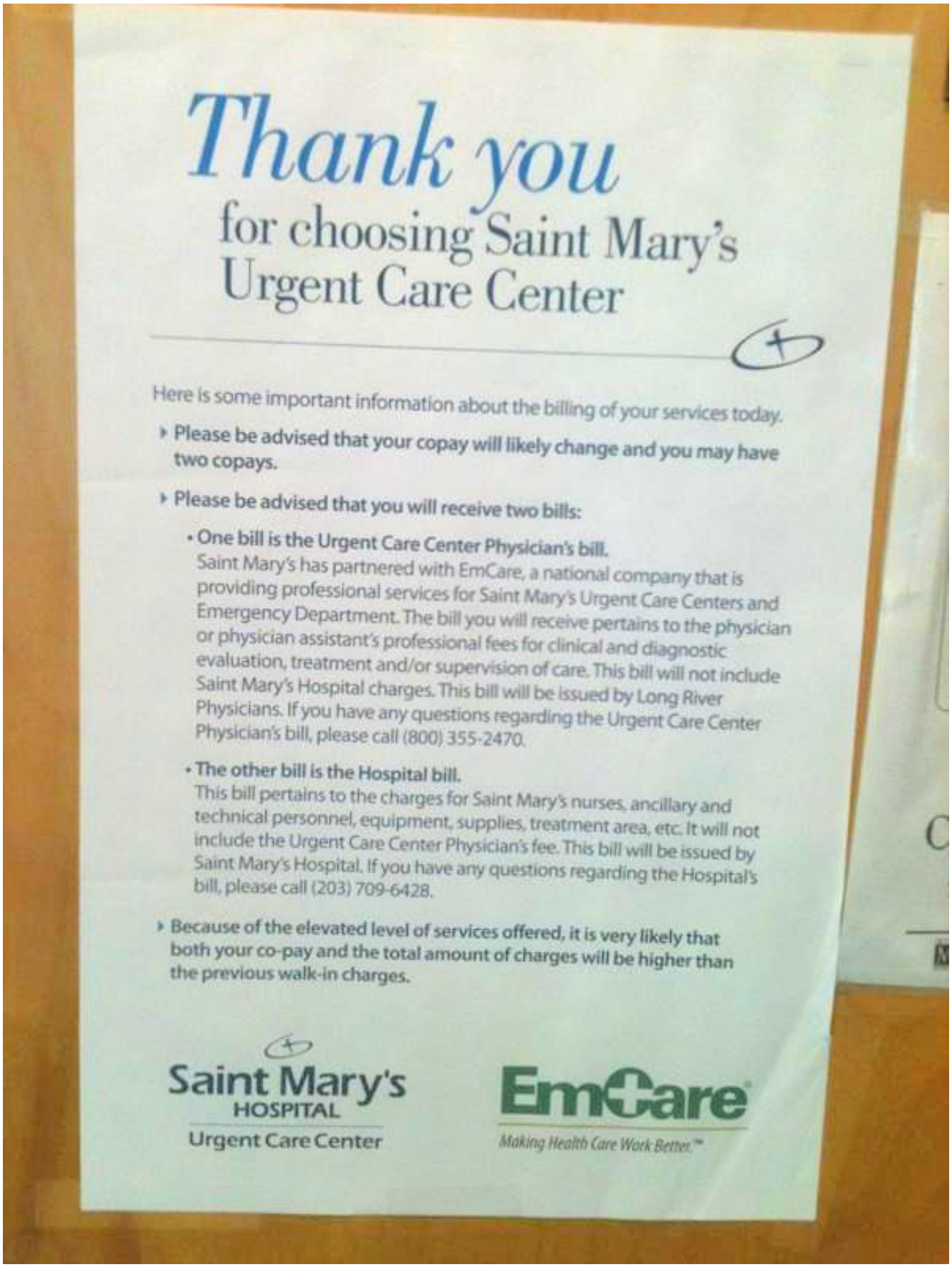
Long River Physician
100 Witmer Road
Suite 220
Horsham, PA 19044
215-442-5046

Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
203-709-6428

Saint Mary's
HOSPITAL
Urgent Care Center

Saint Mary's
HOSPITAL
Urgent Care Center
Lab / Blood Draw Hours
Monday - Friday 7:00am - 6:00pm
Saturday 7:30am - 2:00pm
Sunday 9:00am - 1:30pm
Walk-In / Radiology
Monday - Friday 9:00am - 6:30pm°°
Saturday 9:00am - 4:30pm°°
Sunday 9:00am - 1:30pm°°
°°Last Patient Registered
WARNING
STERLING

The care you need
when you need it.
Expert medical care without the Emergency Room wait
Convenient hours and parking
No appointment needed
Most insurances accepted
Saint Mary's
HOSPITAL
Urgent Care Center



Thank you
for choosing Saint Mary's Urgent Care Center

Here is some important information about the billing of your services today.

- **Please be advised that your copay will likely change and you may have two copays.**
- **Please be advised that you will receive two bills:**
  - **One bill is the Urgent Care Center Physician's bill.**
    Saint Mary's has partnered with EmCare, a national company that is providing professional services for Saint Mary's Urgent Care Centers and Emergency Department. The bill you will receive pertains to the physician or physician assistant's professional fees for clinical and diagnostic evaluation, treatment and/or supervision of care. This bill will not include Saint Mary's Hospital charges. This bill will be issued by Long River Physicians. If you have any questions regarding the Urgent Care Center Physician's bill, please call (800) 355-2470.
  - **The other bill is the Hospital bill.**
    This bill pertains to the charges for Saint Mary's nurses, ancillary and technical personnel, equipment, supplies, treatment area, etc. It will not include the Urgent Care Center Physician's fee. This bill will be issued by Saint Mary's Hospital. If you have any questions regarding the Hospital's bill, please call (203) 709-6428.
- **Because of the elevated level of services offered, it is very likely that both your co-pay and the total amount of charges will be higher than the previous walk-in charges.**

Saint Mary's HOSPITAL
Urgent Care Center

EmCare
Making Health Care Work Better.™

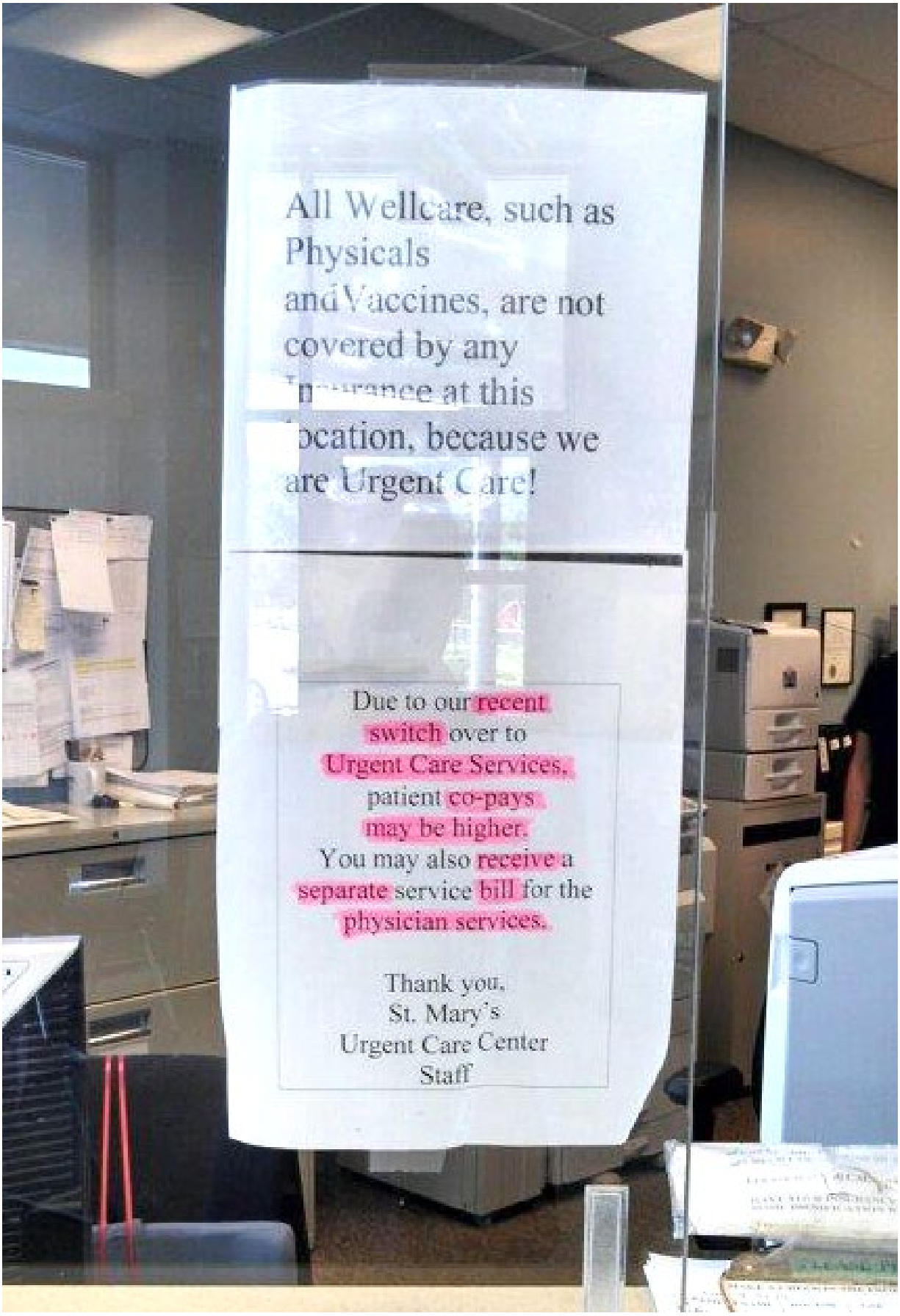

All Wellcare, such as
Physicals
and Vaccines, are not
covered by any
at this
location, because we
are Urgent Care!
Due to our recent
switch over to
Urgent Care Services,
patient co-pays
may be higher.
You may also receive a
separate service bill for the
physician services.
Thank you,
St. Mary's
Urgent Care Center
Staff

EXHIBIT 19

Saint Francis *Care's* Community Health Outreach Programs

Caring for the community beyond the hospital walls has long been a priority for Saint Francis *Care*. By bringing its services into the community through programs which focus on community health, Saint Francis is able to embrace a myriad of creative solutions for improving our community's health.

Saint Francis' commitment to community health is best demonstrated by the establishment of the Curtis D. Robinson Center for Health Equity (begun as an Institute in 2009) **:** a dedicated platform dedicated to eliminating disparities in healthcare and serving as a leader in health equity. Housed within the Urban League of Greater Hartford, this unprecedented Saint Francis Board-endorsed initiative serves as a hub for community engagement, data collection and use in understanding needs of our community, and bridging the resources of Saint Francis with all communities we serve. Here you will find a multi-cultural, multi-lingual team of physicians, nurses and outreach staff harnessing the health system resources into the identified needs of families in our service areas of Connecticut. They include culturally-appropriate health assessments, health education; community-based clinical services such as health screenings and immunizations. A key principle of the Center's activities is to be culturally and community informed. A survey, for example, indicating the health priorities of 700 African American and Latino members of the community helps give focus to health outreach activities.

Saint Francis *Care* also Saint Francis *Care* partnered with like-minded organizations such as the Hartford Hispanic Council, Tuskegee University, local area places of worship and other community organizations to focus on specific health needs of minority populations in its service area and culturally inclusive training for employees. These health equity initiatives demand a strategic approach to health equity informed by the communities we serve, our partners, and our Saint Francis' team committed to measuring impact on improved care. Hence, research, community engagement, education, and bridging health resources to those seeking care are core activities identified with the Curtis D. Robinson Center for Health Equity.

Examples of our recent successes:

- The 4th Annual Town Hall Meeting – 11/18/14 "Is Our Food Making Us Sick?" sponsored by the Curtis D. Robinson Center For Health Equity provided information to the community in the areas of food policy, nutrition, obesity, reduction and health and community organizing around health issues. The Center nurtures ongoing leadership to bring simple

solutions to complex issues that honor the many contributions needed to assure equitable health for our region.

- Saint Francis Hospital and Medical Center Breast Feeding Heritage and Pride - Saint Francis Hospital and Medical Center in partnership with the Hispanic Health Council has just received a three year grant to expand a program that trains low income African American and Hispanic mothers who are patients of the Saint Francis Center for Women's Health. Through this program women are encouraged to breast feed their newborns using trained peer counselors. The goals of this program are to reduce the risk of Sudden Infant Death syndrome, asthma, allergies, respiratory infections and other problems among newborns in this population of women. Breast feeding also provides vital nutrients for growth and development, encourages development of mouth and jaw and reinforces the mother/baby emotional bonding.
- Maternal Infant Outreach Program (MIOP) – The goals of the City of Hartford MIOP program are to monitor health conditions of high-risk pregnant women in Hartford, to assess preventable risk factors associated with low birth weight, and to help identify effective and ineffective elements of existing efforts. Saint Francis Hospital and Medical Center has participated in this program for many years. Services provided by Saint Francis include pregnancy tests, prenatal care, patient education and nutritional counseling, routine gynecologic care, breast exams, cervical cancer prevention, post-menopausal counseling and hormone therapy along with STD and HIV testing and counseling. MIOP is a system of care that is proven and has demonstrated its effectiveness through reduced infant mortality rates, lower number of babies born with low birth weights, increased number of women accessing prenatal care, higher number of women having full term babies, and more linkages and services to families.

In addition to these targeted programs seeking to address service inequities for minority populations in its service area Saint Francis Care offers a wide range of community education programs to its entire service area population. Those programs are listed below:

Caregiver Support Services

- CREC Magnet School Partnership
- Golfers in Motion Program
- Health Equity Fellowship
- Housing Support
- Joan C. Dauber Food Bank
- Keep-the-Power-On Utility Clinic programs that address underlying social problems, such as poverty, homelessness, and environmental issues.

These activities support community assets by offering the expertise and resources of the healthcare organization.

• Literacy Support Programs
• Medical Legal Partnership Program
• Nurturing Families Network Case Management Services
• Pastoral Counseling Program
• Procurement of Pharmaceuticals for Indigent Clients
• Services for Children and Families Impacted by Child Abuse
• Support for Malta Van Services Healthcare Support Services
• Support of Neighborhood Associations
• The Auxiliary Repetitions Thrift Store

Community Health Education

• Bereavement and Spirituality Classes
• Break Free from Smoking Program
• Breastfeeding Support
• Cancer Support Groups
• Cardiac Rehab and Wellness
• Care Management Support Services
• Center for Diabetes & Metabolic Care Program Education and Outreach
• Child Abuse Prevention Education and Outreach
• Childbirth Education Classes
• Colorectal Screening Program
• Community Lectures on Health Promotion, Early Detection, and Disease Management Topics
• CPR and Safety Programs
• Diabetes Support Services
• Domestic Violence Prevention Training
• Golfers in Motion
• Healthy Start and Parenting Programs
• Integrative Health Services Classes
• Lead Poisoning Prevention Education and Outreach
• Mental Health Alliance and Support
• Multidisciplinary Case Management Team for Child Abuse
• Nutrition and Weight Management Programs
• Powerful Tools for Caregivers Program
• Preventive Health Screenings:
- Bone Density Screenings
- Cardiovascular Risk Assessment
- Child Seat Safety
- Diabetes Screening
- Mammograms
- Prostate Cancer
- Skin Cancer Screenings
• Support Groups including

-Amputee Information Series
-Stroke Support Group
-Aphasia Support Group
-Spinal Cord Injury Support Group
-Living with Multiple Sclerosis
-Living with Congestive Heart Failure
-High-risk Pregnancy
-Pregnancy and Infant Loss
• Violence and Injury Prevention Program
• Women's Heart Program Outreach Community-Based Clinical Services

Other Health Improvement Services
• Access to Recovery for Substance Abuse Clients
• Adaptive Rowing Program
• Breast and Cervical Cancer Education and Outreach

EXHIBIT 20

SAINT FRANCIS Care Policy	**Title:** **Financial Assistance Policy**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Patient Accounting	**Number** ADM 060	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 11/2/2015	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital (the "Hospital") to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by the Hospital for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

SCOPE:

This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures, bariatric services and secured liens on liability cases.

Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided:
    a. Family size - as reflected on prior year tax return; and
    b. Income verification – to include one of the following:
        i. Four most current pay stubs;
        ii. A letter from employer or government agency which verifies income and previous year's tax return; or
        iii. Active Medicaid eligibility screen print that indicates current full Medicaid coverage

    If any of the above required documents are not received, the application will be pending for thirty (30) days. A written notification will be sent to the applicant detailing the missing documentation. If the missing documentation is not provided within twenty (20) days, the application will be denied. An approved application will cover all previous covered services and as well as future qualifying services for the next six (6) months.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with a verified income below 100% of the poverty guidelines. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown, the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

  Effective 1/1/2014: Un-insured applicants must complete an application through Access Health during open enrollment for eligibility determination for a qualified health plan, or HUSKY Health..

4. Eligibility is determined on family size and current income.

   a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.

   b. Patients with income levels ranging between **200% to 250%** of the federal poverty guidelines and who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

   Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

   Examples:

   - If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.

   - If the insurance payment is less than the Medicare allowed amount, the patient is responsible to pay up to the Medicare allowed amount. Any amount over the Medicare allowed amount will be adjusted with the financial assistance code 97000039 or 5017.

   - Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:

     - Reached their maximum benefits

     - Entire procedure is non covered due to limitations of their policy or diagnosis

     Patients within the 200-250% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

     Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel must determine eligibility within thirty (30) days of receipt of a completed application.

6. Assessment for other free bed funding is completed as part of the financial assessment.

PRESUMPTIVE SUPPORT:

The Hospital recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted, it is classified as "Presumptive Support." No application is required for this group.

Examples of presumptive cases include:

- Deceased patients with no known estate;
- Homeless patients;
- Patient bankruptcies;
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through religious order and
- Patients who are qualified for other State Assistance Programs that are income based.

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

<$4,999 - Customer Service Rep/Financial Counselors/Team Leads
$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from financial assistance
- Liability Cases that have secured liens are excluded from financial assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.
- Applications are approved for six (6) months.
- Patients with non-contracted insurance carriers or medically necessary non-covered services may be eligible for a discount up to 45%on a case by case review (no application required).

CROSS REFERENCES:

Self Pay Billing and AR Management Policy
Emergency Medical Screening and Stabilization/ EMTALA

APPROVED BY: Policy requires Vice President approval.

Nicole Schulz	Date:
Vice President	11/2/2015

REPLACES:

Financial Assistance Policy 1/30/2015

1

SAINT FRANCIS Care Policy	**Title:** **SELF PAY BILLING AND AR COLLECTION POLICY**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Business Office	**Number** ADM 064	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 1/30/2015	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE: It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a summarized bill including but not limited to encounter specific information including dates of service, summarized charges, discounts, payments, adjustments and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the Access Health CT, State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial assistance program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time (4 statements or 120 days) to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.
- Return mail without other non-identified information is returned, the account may to collections before 120 days.

SCOPE:

This policy applies to the Business office and hospital staff

POLICY:

Self-Pay Billing: Execution of the self-pay billing cycle.

Primary self-pay balances, those balances for which there is no insurance coverage, or self pay balances after insurance has been processed, will receive a series of four statements when the account is released from billing.. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, an account is generated and held for the appropriate min days which allows the charges to be associated with the patient encounter. After the min days are satisfied the account is moved from pre-receivable status to active accounts receivable status in the hospital's receivable system.
- Second, a statement displaying a summary of the total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Simultaneously a file containing the billed inventory is electronically transferred to a contracted self-pay customer service agent to initiate contact and work with patients for account resolution.

Each statement includes a specific message based upon the status and age of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement (payment plan) will receive an alternative self-pay dunning cycle. Payments on payment arrangements must

have consistent payment in accordance with the plan. If installment payments are missed the account is eligible for collection.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay accounts are assigned to a contracted customer service agent from the day the account is ready for billing. The contracted agent receives daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through Access Health CT, the State of Connecticut's Medicaid Assistance program, as well as St. Francis' internal financial assistance program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing consistent monthly payments for the agreed upon amount are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt and written of at the end of the month.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

Approval of bad debt accounts are as follows:

$5,000-$24,999 - Supervisor

$25,000-$49,999 - Manager

$50,000-$99,999 - Director of Patient Financial Services

>$100,000 - VP, Revenue Cycle

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above.
- Any unpaid balance in bad debt with no activity for 180 days, will be returned to the hospital and get referred for secondary placement see **AAB & LEVIN BAD DEBT RETURNS TO EOS CCA PROCEDURE**

REFERENCES:

CROSS REFERENCES: Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and AAB & LEVIN Bad Debt returns to EOS CCA procedure.

APPROVED BY: Policy requires Vice President approval.

Vice President(s):	Date:		Date:
Nicole Schulz Vice President Revenue Cycle	1/30/2015		

REPLACES:

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11; 07/29/2011; 5/22/2013, 2/6/2014;

EXHIBIT 21

A Community Health Needs Assessment

Department of Health and Human Services

March 2012

Healthy Hartford

The mission of the Hartford Department of Health

and Human Services is:

To protect the well-being of the people in Hartford, to promote an environment conducive to healthy lifestyles, and to prevent adverse health outcomes. Whenever possible, the Department will endeavor to employ strategies, policies and interventions through community partnerships to reduce health disparities.

A Community Health Needs Assesment

Hartford Department of Health and Human Services

This report is funded in part by:

Hartford Hospital

Connecticut Children's MEDICAL CENTER

SAINT FRANCIS Hospital and Medical Center

Acknowledgements

Community Health Needs Assessment Consortium
City of Hartford Department of Health and Human Services
Connecticut Children Medical Center
Hartford Hospital
Saint Francis Hospital and Medical Center
University of Connecticut Health Center

Under the direction of the Community Health Needs Assessment Consortium, the Community Health Needs Assessment Workgroup began planning this assessment in early 2010. Much thought was put into creating a process and document that would be both useful and enlightening to healthcare organizations, community-based health and social services organizations, and the community at large. The City of Hartford Department of Health and Human Services wishes to thank our community health needs assessment partners for their generous support to this project and to their designated representatives on the Community Health Needs Assessment Workgroup for their professional contributions and collaborative efforts throughout the study process. Special thanks go to the Urban Alliance for providing data, analysis, and review of the Hartford Survey Project: Understanding Needs and Service Opportunities.

We would also like to thank Holleran Consulting LLC for their expertise in community health assessments and for preparing the community profile. This document has been produced for the benefit of the community. The City of Hartford Department of Health and Human Services and its community health needs assessment partners encourage use of this report for planning purposes and are interested in learning of its utilization. We would appreciate your comments and questions, which may be directed to the City of Hartford Department of Health and Human Services by phone at (860) 757-4700.

The report, as well as the raw data used to generate our findings is available for download at: http://hhs.hartford.gov.

City of Hartford
Department of Health & Human Services
131 Coventry Street
Hartford, CT 06112

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The goals of this CHNA are:

- To provide a baseline measure of key health indicators
- To inform health policy and health strategies
- To provide a platform for collaboration among community groups including schools, businesses, policy makers, and others to impact current health status
- To act as a resource for individuals, agencies, and institutions looking to identify community health needs and priorities
- To establish benchmarks and monitor trends in health status of Hartford residents
- To assist with community benefit requirements as outlined in the PPACA

The information included in the CHNA provides the foundation upon which community health programs and interventions can be targeted, developed, and evaluated with the ultimate goal of improving the health of the community and its members.

II. Summary of Key Findings

Social Determinants – Many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings in the secondary data profile point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. The Key Informant interviews, the Hartford Survey Project, and data from the Health Equity Index validate the concern for marginalized and underserved populations.

- The top 5 quality of life issues mentioned by Key Informants as currently having the most negative impact in Hartford were **poverty**, **job opportunities**, **quality of housing**, **neighborhood safety**, and **education**.

- Hartford has a greater number of renters than owners, more households with mothers being the sole head of household, and lower residential property values than the state, overall. These are associated with poor health outcomes. There is also a higher rate of service occupations when compared to the state and nearly 1/5 of the city's labor force unemployed. With subpar housing and employment levels, overall economic security rates low.

- Nearly a third of Hartford's adults do not have a high school diploma, and the average graduation rate is 77%; high educational attainment is one of the key determinants of community health since it leads to increased economic security and occupational prestige.

- More than 10% of all of the crimes committed in Connecticut in 2009 were committed in Hartford, even though Hartford accounts for less than 4% of Connecticut's population, and there are certain types of crimes that occur with greater frequency in Hartford than in the state overall.

- Compared to other Connecticut cities, the overall environmental quality in Hartford is poor; HEI scoring for waste stream and water discharge pollutants were low. The underlying perception of the city as "unclean" could also impact individual health decisions.

- Less than half of Hartford's residents are registered to vote; a trend that is often associated with fewer community resources and support networks.

Health Indicators

Cancer incidence for all types (specifically lung and prostate) is well below the national and state levels; however, it is important to keep in mind that Hartford has a relatively young population when compared to state and national figures. Key Informants also perceived cancer as less of a priority with only 11.9% respondents ranking it within their top five health issues.

- In general, chronic lower respiratory disease death is lower in Hartford than across the nation or in the state; however, asthma hospitalization rates in Hartford are much higher when compared to the state, with children and adult rates that are at least three times higher than the state rate. Asthma, not one of the options provided in the Key Informant survey, was the most frequently written-in health issue by participants.

- Although one of the top health issues identified by Key Informants was violence, most respondents perceive that violent acts, while isolated in Hartford, are a product of a depressed economic situation. Hartford accounts for more than a third of all murders in the state, and experiences a higher percentage of assaults. This disproportionate and avoidable indicator negatively impacts the overall quality of life in the city.

- There is a much younger population in Hartford compared to the state and nation that is reflected in the mortality rate. This is also reflected in a lower occurrence of the top ten national causes of death, which are often age-related. However, the much higher age-adjusted rate suggests that the elderly population, albeit small, is dying at a very high rate. Infant and neonatal death rates are much higher in Hartford than the state and nation. Hartford also has considerably higher rates of infectious/communicable diseases than the state.

- There is an indication that obesity is a concern for Hartford. Health indicators for heart disease are worse for Blacks and Hispanics, and those who live below the poverty threshold; diabetes rates in Hartford have been increasing in recent years.

Access to Care – Access to care was commonly cited in both the Key Informant study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

III. Methods: How We Obtained the Data

The data in this report were compiled from a variety of resources, and includes both quantitative and qualitative data. Additionally, it includes very specific information on critical health indicators and broader information regarding the social determinants of health.

The CHNA report synthesizes findings and data from the following three sources:

Key Informant Interviews – Each Workgroup member identified 5 to 10 people in management or leadership positions with various community organizations including health and human services, religious organizations, and government agencies; 85 unique Key Informants were identified by the Workgroup. Respondents were asked to critically evaluate health needs pertinent to the community through their experience. Survey questions focused on underserved populations and access to care issues in Hartford. In total, 59 interviews were conducted; see Appendix for a complete list.

The Hartford Survey Project – In order to better understand Hartford's human service needs and barriers to receiving services, a face-to-face survey conducted by the Urban Alliance was completed between October 2010 and January 2011. 402 resident surveys were completed at 12 locations throughout the city to promote geographical and ethnic diversity among respondents; these locations included grocery stores, pharmacies, and community events and programs. Respondents were asked if they would benefit from any of 12 service areas, the possible barriers to obtaining these services, and which three areas of the 12 have a need for additional services. In addition, they were asked to rank the top three service areas in Hartford that they believed were in most need.

Of the total respondents, 57% were female and 43% were male. The ethnicity breakdown was 39% African American, 37% Latino, 9% white, and 8% West Indian. Age categories for respondents were 27% between 18 and 29 years old, 42% between 30 and 49, 24% between 50 and 64, and 6% were 65 and older.

Secondary Data – Holleran, in coordination with HHS, prepared the initial community profile for Hartford from secondary data sources. In addition the following sources of data were used throughout this assessment:

- Connecticut Department of Public Health Vital Statistics and Health Outcomes
- Women's Health Quick Health Data Online via the Office on Women's Health (US Department of Health and Human Services)
- Health Data Interactive via the Centers for Disease Control and Prevention
- Connecticut Labor Market Information via the Connecticut Department of Labor

There was also an analysis of local, state, and national 2009 U.S. Census Bureau data collected via the annual American Community Survey; this data is available via the Census Bureau's website.

HHS was also able to use the Connecticut Health Equity Index (HEI) to build upon and enhance the findings from the original information. Developed by the Connecticut Association of Directors of Health (CADH), a non-profit membership organization that represents local directors of health departments and/or districts in the state, the HEI can be used to identify social, economic, and environmental conditions and their correlations or relationships to specific health outcomes. Key social determinants of the HEI include: civic involvement, community safety, economic security, education, employment, environmental quality, and housing. Collectively, these social determinants form the fabric of social and economic opportunity and a healthy environment, as well as provide insight to how social determinants may affect health outcomes and health care services of various populations living in the area of interest. The HEI is an excellent tool for determining how social factors are associated with community health, and by using up-to-date data sources, HEI's commitment to quality improvement evolves along with Connecticut's communities.

Hartford is one of three pilot sites in the state that was selected to test and evaluate the HEI for its use in mobilizing a community, stimulating sustainable action, increasing knowledge of health equity concepts and their application, and prompting structural changes that reflect local needs. Data collection for the HEI began in 2007 and continues through 2012. The HEI is based on a ten-point measurement scale, where 1 is a low score, which represents a less favorable community condition or health outcome, and 10 is a high score, which symbolizes a more favorable community condition or health outcome.

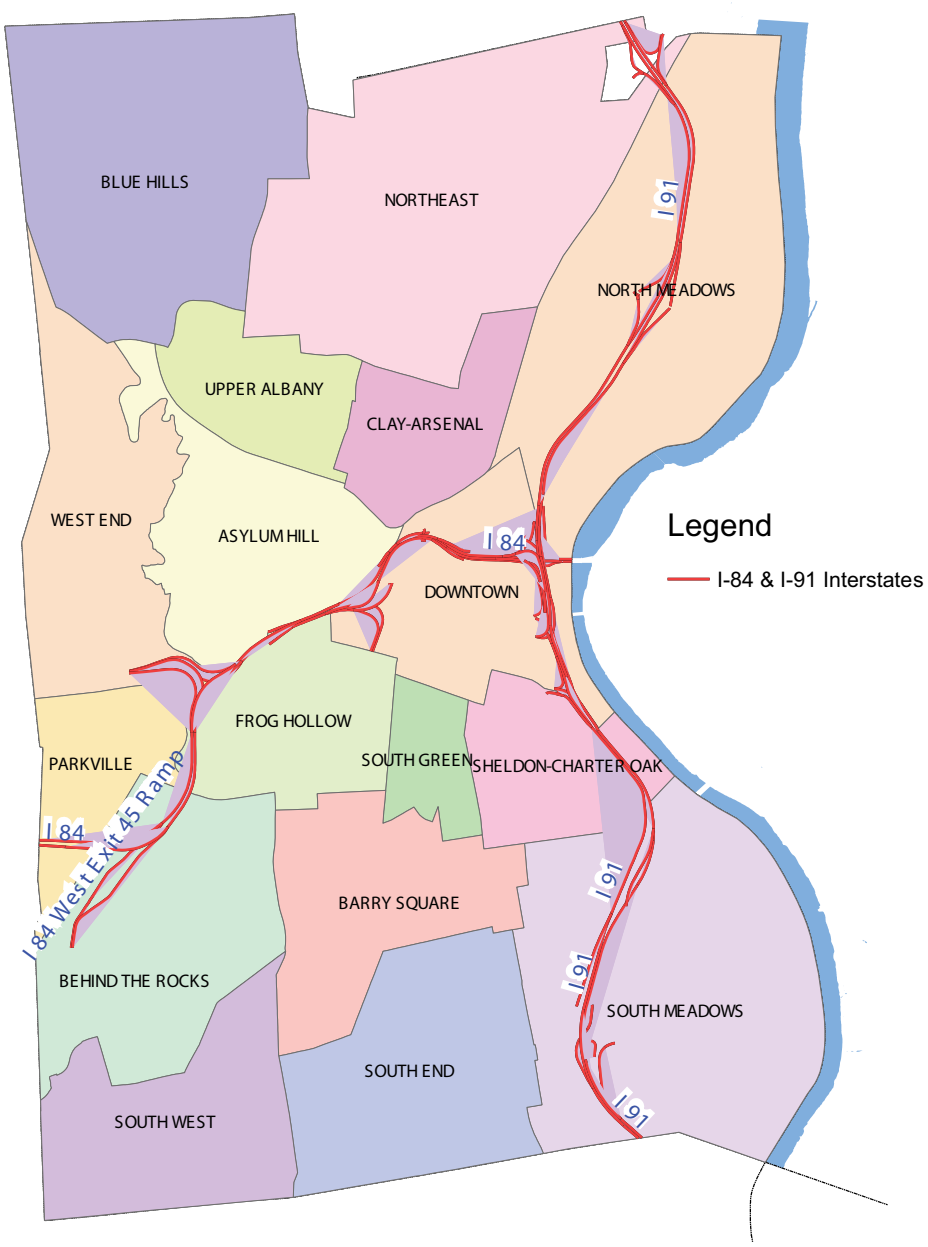
HEI maps were used to compare neighborhoods by social determinant or health outcome indicators. This comparison includes both the North Meadows and South Meadows neighborhoods for analysis, although the former is mainly comprised of car dealerships and landfill, and the latter with a small airport, a water pollution plant, and various commercial and industrial businesses. Together, both neighborhoods are home to less than 3% of Hartford's total population and must be considered when viewing the maps.

A feature of the HEI is that for every social determinant listed (civic involvement, community safety, economic security, education, employment, environmental quality, and housing), the varying factors used to determine the indexing are analyzed with each of the health outcomes in the index (accident/violence, cancer, cardiovascular, childhood illness, diabetes, health care access, infectious disease, life expectancy, liver disease, mental health, prenatal care, renal disease, and respiratory illness). Strength correlations are derived using Spearman's rank correlations, and are generated between the social determinant selected and significant health outcomes. The strength of a correlation is measured between 0 and 1, and the closer the coefficient is to 1 the stronger the correlation between the measures; a correlation of 0

signifies no statistical relationship between measures. Direction of a correlation is measured by signaling a correlation as positive or negative. A positive correlation signals a direct relation between two measures, while a negative correlation signals an inverse relationship. All correlations generated by the HEI are statistically significant.

The maps displayed throughout this report use a color gradient to indicate how Hartford neighborhoods rank with each other with regard to a specific social determinant or health indicator; the darker the color means the lower the rank. The subsequent map is a legend for all Hartford neighborhood names and should be referred to for neighborhood identification.

Map 1. **City of Hartford and Neighborhoods**



IV. Demographics

Hartford is the capital of the State of Connecticut and the seventh largest city in New England. At almost 400 years old, Hartford is one of the oldest cities in the country and at one point was one of the wealthiest. Still rich with history, it is home to the oldest public art museum and oldest public park in the nation. Starting in the late 1950s, many of the city's residents began moving to the suburbs, possibly accelerated by the construction of two major interstate highways intersecting within the city. And even though the metropolitan area ranked 32 out of 318 nationally in total economic production (second behind San Francisco in per capita economic activity) and the sixth lowest poverty rate of all Metropolitan Statistical Areas (metropolitan statistical area is a geographical region with a relatively high population density at its core and close economic ties throughout the area) for the 2010 census, the city itself remains one of the poorest in the nation; 31.9% of all its residents, and 38.3% of its families with children under 18 years old are living below the poverty line.

The population in Hartford is 124,775, with a **gender** ratio close to state and national ratios of 49% male and 51% female. Hartford is proportionally younger than the state and the U.S., which impacts numerous aspects of health including rates of some types of cancer, violence, and levels of unintended injury.

Table 1. **Age Categories for Hartford, Connecticut and the U.S.**

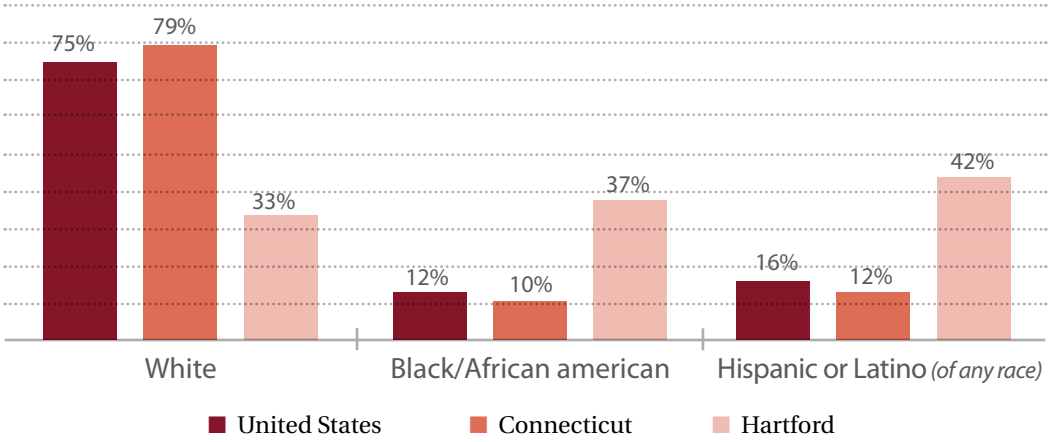
	HARTFORD	CT	US
0-19 years	**34%**	26%	27%
20-44 years	**37%**	32%	34%
45-64 years	**20%**	28%	26%
65 and older	**10%**	14%	13%

The **ethnic composition** of Hartford is mostly a mix between Hispanic/Latino of any race, Black/African American, and white. Hartford's white population is at a lower ratio than the U.S. and state while the proportion of Black and Hispanic/Latino residents is significantly higher. Ethnic variation in cultural norms, English comprehension, and beliefs about health impact the mode of health care delivery and how patients respond to health care services. This variation creates a need for increased awareness and sensitivity among service providers.

A significant percentage of Hartford residents can trace their heritage to Puerto Rico and the West Indies; in the 1940s, many immigrants from these areas moved to Connecticut to work in tobacco fields. 78% of Hartford's Hispanic/Latinos self-reported to be Puerto Rican in the 2010 census. Typically, West Indians are grouped with "Black/African American" in census data, which makes it difficult to highlight cultural differences. However, it is important to

note that the ethnic landscape in Hartford is changing as a greater number of families and individuals from Eastern Europe, Africa, and Southeast Asia continue to make Hartford their home.

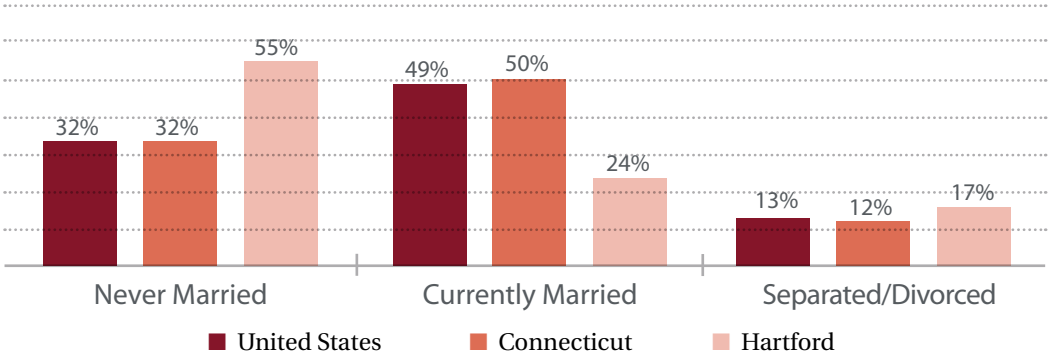
Figure 1. **Ethnic Composition for Hartford, Connecticut, and the U.S. (2009)**



This ethnic breakdown impacts the primary **language spoken** at home. The percentage of Hartford's population who only speak English is 52%, which is lower than a state and the nation comparison. Additionally, approximately 35% of Hartford residents speak a language other than English; the high percentage of non-English speakers could pose a barrier for access to all kinds of health promoting opportunities.

With regard to **marital status**, Hartford's population has a notably larger percentage of people who have never been married when compared to the state and the nation; the City of Hartford also has a smaller comparative percentage of people who are currently married and not separated. The data regarding separated/divorced residents and widowed residents are similar to state and national averages; however, the rate of legally separated couples (de facto separation while remaining legally married) in Hartford (5%) is twice that of the nation (2%).

Figure 2. **Marital Status Statistics for Hartford, Connecticut, and the U.S. (2009)**



VI. Social Determinants of Health

Quality of life issues are indicators that include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging [2]. During this assessment, Key Informants were asked a variety of questions about quality of life in Hartford. For nearly all quality of life questions, 50% or more of informants ranked them as "Poor" or "Very Poor."

Table 2. **Poorly Rated Quality of Life Measures by Key Informants**

QUALITY OF LIFE	RATED "POOR" OR "VERY POOR"
Poverty	93.1%
Job opportunities	87.3%
Quality of housing (affordable, in good condition)	72.4%
Neighborhood safety	71.9%
Schools/education	65.5%
Clean, litter-free neighborhoods	63.1%
Road/traffic conditions	53.6%
Availability of recreational activities	52.6%
Availability of care for children	31.6%
Water or air pollution	26.4%

This information provides insight for those who are regularly involved in the health and human services sector. The following section will addresses social determinants of health, and how Hartford rates relative to state and national figures.

Housing

Adequate housing provides shelter and comfort to its inhabitants, both of which impact overall well-being. One of the measures used to evaluate the association of housing and health is the number of subsidized housing units per 1000 local residents as defined by the Connecticut Housing Finance Authority. Using 2005 data, the HEI correlated housing strongly with infectious disease in Connecticut, and Hartford received the overall lowest housing score in the HEI when compared to the rest of the state.

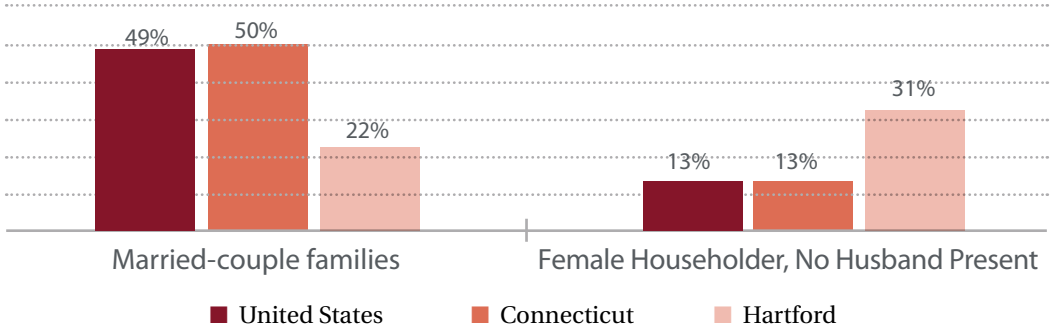
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia and/or gonorrhea, asthma hospitalizations, infectious and parasitic diseases, homicides, drug-induced deaths, mental health hospitalizations, and births not receiving prenatal care in the first trimester.

A cursory analysis of **housing occupancy** in Hartford reveals that the city has over 44,000 occupied housing units of which 26% are owner-occupied; the state average is 69%. A higher rate of rental units is associated with poorer quality of housing and impacts health. Over 70% of Key Informants surveyed ranked housing quality at either "Poor" or "Very Poor." Further highlighting the housing issue, homelessness was the issue recognized as most in need of additional services by those surveyed by the Urban Alliance (45%).

Lower residential property values, accompanied by lower sales prices and a greater number of foreclosures are strongly associated with lower quality neighborhoods. Neighborhoods with these negative housing characteristics typically have higher crime rates, lower quality school systems and a poor physical environment (sidewalks, parks and properties). For 2010, the average assessed residential property value in Hartford was $43,689, which is significantly lower than the state's average value of $209,025; and the average sales price of an existing home was $164,462, which is lower than the state's average home sales price of $288,948.

Hartford **household statistics** for family (59%) and non-family households (42%) are similar to state and national rates, but deviate substantially for the percentage of female householders with no husband present (much higher than state and national) and the percentage of married-couple families (much lower than state and national). Additionally children in Hartford are almost three times as likely (19%) than those in the rest of Connecticut (7%) to live in households with no husband present.

Figure 3. **Household Types for Hartford, Connecticut, and the U.S. (2009)**



In the HEI, Hartford has a housing indexed score of 3, which is a less favorable condition in this category. Some of the calculating factors used to determine this score are rental vacancy rates as a percentage of rental units, owner occupied housing as a percentage of total housing units, and median gross rent as a percent of household income. These measures were calculated using data from the 2000 US Census.

Table 3. **Health Indicators Related to *Housing***

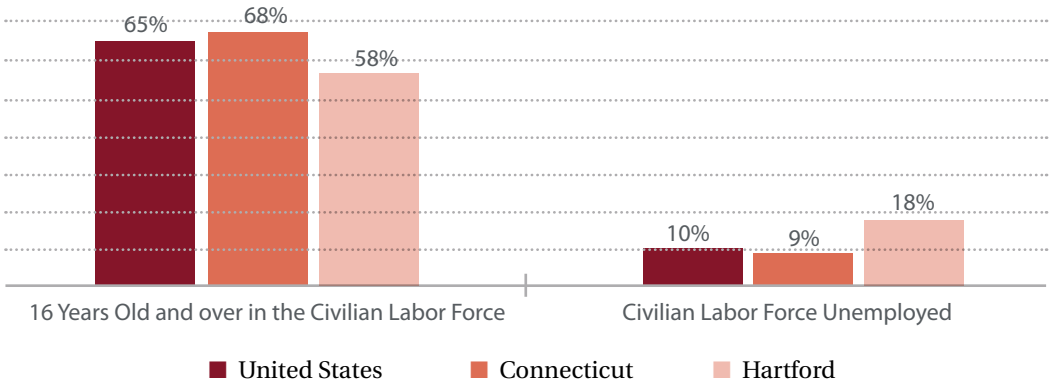
	HEI INDEX	CORRELATION COEFFICIENT
Infectious Disease	2	0.55
Health Care Access	2	0.47
Childhood Illness	1	0.42
Accidents/Violence	3	0.40
Mental Health	2	0.37
Renal Disease	2	0.33
Life Expectancy	3	0.31
Cardiovascular	3	0.29
Respiratory Illness	4	0.29
Diabetes	3	0.24
Perinatal Care	3	0.22
Liver Disease	2	0.20
Cancer	5	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Employment

As of September 2011, Hartford's unemployment rate was 15.6% according to the Connecticut Department of Labor's Labor Force Data, which is nearly twice the rate as the United States (8.8%). Against this backdrop, it is fitting that surveyed residents of Hartford rank job training/employment assistance as one of the top three service needs in the community. Key Informants had a similar view with 87% ranking job opportunities in Hartford as "Poor" or "Very Poor."

Figure 4. **Employment in Hartford, Connecticut, and the U.S. (2009)**



The percentage of workers in Hartford in management, professional, and related occupations (21.1%) is smaller than the state and nation (40.3% and 35.7%, respectively). Conversely, the percentage of those in the labor force with service occupations is much higher in Hartford

(34.4%) than across Connecticut and the nation (17.3% and 17.8%, respectively). With this disproportionate representation of Hartford residents across these occupational groups and the strong correlation between employment and health care access, one can see how Hartford struggles to maintain a healthy community profile.

Table 4. **Health Indicators Related to *Employment***

	HEI INDEX	CORRELATION COEFFICIENT
Health Care Access	2	0.54
Childhood Illness	1	0.48
Accidents/Violence	3	0.37
Life Expectancy	3	0.35
Respiratory Illness	4	0.28
Infectious Disease	2	0.28
Cardiovascular	3	0.28
Perinatal Care	3	0.26
Mental Health	2	0.23
Cancer	5	-0.19

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

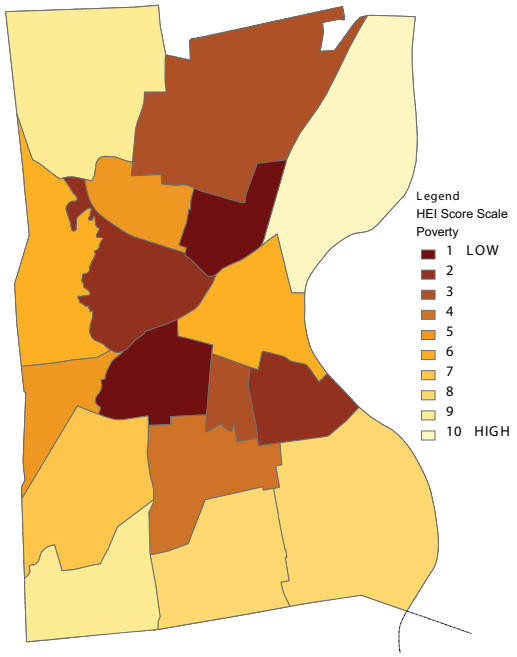
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

Economic Security

Hartford received the lowest possible score on the HEI for the majority of factors that determine economic security. Additionally, 93% of Key Informants rated Hartford's poverty level as either "Poor" or "Very Poor" on the Quality of Life section of the survey. Results from the Urban Alliance survey were similar, with employment opportunities and financial assistance topping the list of services needed. According to a report from the Robert Wood Johnson Foundation, income and educational attainment are the two most commonly used markers of socioeconomic status or position in the United States [3]. Both are strongly related measures of health and health-related behaviors. These factors can influence health through the direct effects of extreme poverty (such as malnutrition or exposure to extreme heat or cold) as well as health effects due to chronic stress; these can include the triggering and exacerbation of depression and cardiovascular disease [4].

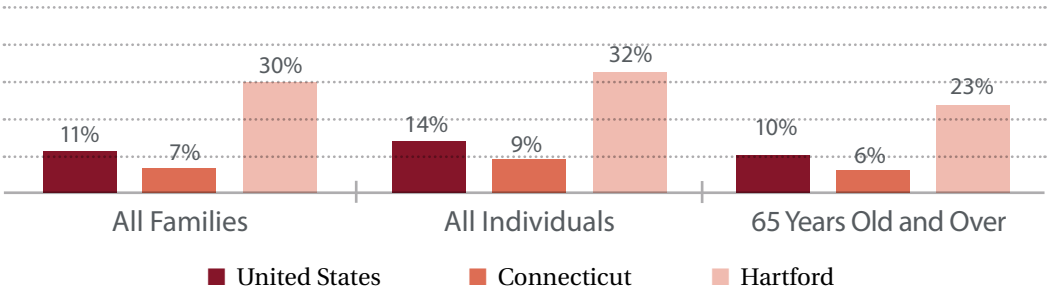
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

Map 2. **HEI Poverty Score by Neighborhood**



With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. Similar patterns have been documented for residents and for those over the age of 65.

Figure 5. **Poverty in Hartford, Connecticut, and the U.S. (2009)**



The **income statistics** for Hartford illustrate that the median income per household and family, are significantly less than the state and national figures.

Table 5. **Income Statistics for Hartford versus State and Nation**

	HARTFORD	CT	US
Median Household	**$28,300**	$67,034	$55,221
Median Family	**$33,805**	$83,069	$61,082

In Connecticut, living in poverty is correlated with higher rates of chlamydia and gonorrhea, trauma-related hospitalizations and ED visits, mental health ED treatments, homicide, hepatitis C, diabetes, drug and alcohol induced deaths, low and very low birth weight babies, and infectious and parasitic diseases.

Education

Just as low levels of employment impact community health, so does low educational attainment. 13.9% of Hartford residents perceive education to be one of the top three needs for the community. Key Informant survey respondents noted that the best way to promote wellness and prevention of illnesses in Hartford residents is through education. One respondent noted that starting with school-age children is the best way to achieve these goals. Another declared that it is necessary to tailor the education to "racial, cultural and other different types of understandings to get to the people of the city," and that the frequency of wellness education should be "not just doing it once a year" in order to convey necessary concepts.

Results from the Connecticut Mastery Test and Connecticut Department of Education were used to establish a connection to community health, as indicated in the following table:

Table 6. **Health Indicators Related to *Education***

	INDEX SCORE	CORRELATION COEFFICIENT
Childhood Illness	1	0.73
Life Expectancy	3	0.64
Infectious Disease	2	0.59
Health Care Access	2	0.57
Accidents/Violence	3	0.55
Cardiovascular	3	0.51
Mental Health	2	0.42
Respiratory Illness	4	0.41
Renal Disease	2	0.39
Diabetes	3	0.38
Perinatal Care	3	0.34
Liver Disease	2	0.21

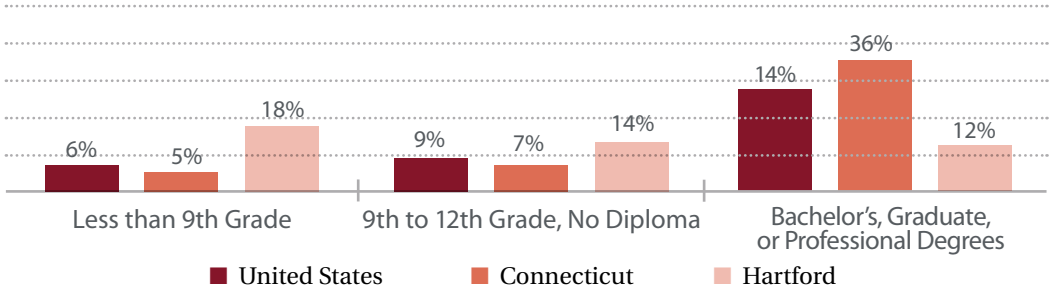
Note: All shown correlations are statistically significant and ranked in order from strong to weak.

As the demographic data indicates, Hartford residents are less likely to graduate from high school and are less likely to obtain post-secondary education when compared to the state or nation as a whole. The strong correlations suggest that a higher educational attainment leads to better health throughout an individual's lifespan, and better health and education enable people to realize their capabilities to be productive members of society [5], with greater potential for positively impacting the community.

In Hartford, low rates of educational attainment are coupled with lower standardized test scores and less frequent renovations of the city's public school facilities; according to the Connecticut State Department of Education's Connecticut Education Data and Research (CEDaR) website, the average number of years since a major renovation for Hartford's elementary, middle, and high schools is 25.8, 33.8, and 17.5 years, respectively. As indicated in the table above, education is correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, diabetes, and infectious diseases; poorer cardiovascular health; and frequency of accidents and violent incidents. Other correlations to education include lower life expectancy, lower rates of perinatal care and health care access, and worse mental health outcomes.

Over 30% of Hartford's adults of 25 years and older do not have a high school diploma, which is significantly higher than the 12% for the state. Conversely, the percentage of Hartford's population with a bachelor's degree or higher is also lower than both state and national figures at 12% when compared to 36% for the state. When these data are examined more closely it becomes clear that the problem of low **educational attainment** begins early for many, with 18% of Hartford residents over age 25 having less than a 9th grade education and another 14% having attained from 9th and 12th grade but without a diploma.

Figure 6. **Educational Attainment of Adults 25 Years and Older for Hartford, Connecticut, and the U.S. (2009)**

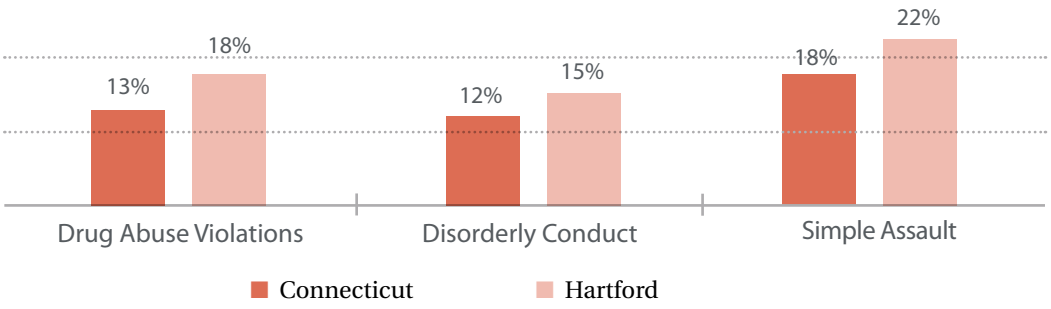


Community Safety

The HEI measures community safety by the rate of crimes against persons or property published by the 2004/2005 Connecticut Uniform Crime Reports, and within this framework Hartford receives the lowest score of 1 indicating high rates of crime. However, the crime statistics found in the Secondary Data Profile are potentially inconclusive because a high

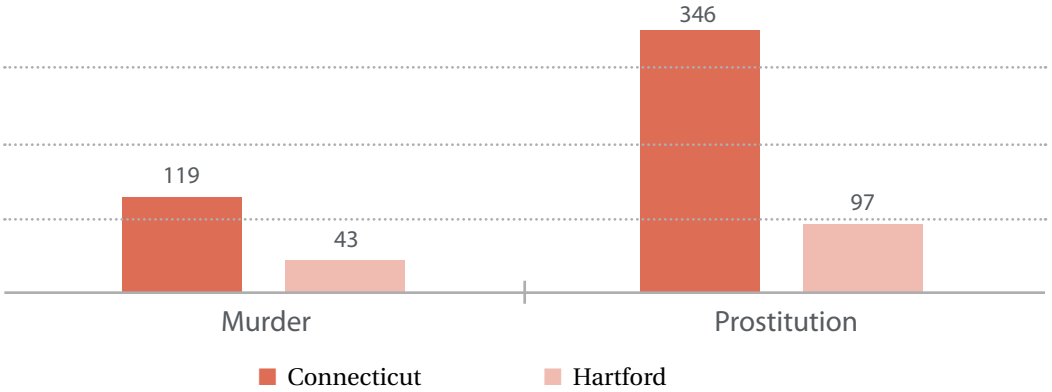
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in Connecticut occurred in Hartford. Moreover, almost 20% of the state's drug abuse violations occur in the city. Other violent crimes that occur more frequently in the Hartford than in the state are simple assault and disorderly conduct.

Figure 7. **Percent of All Crimes in Hartford and Connecticut (2009)**



Over 70% of Key Informants rated neighborhood safety in Hartford as "Poor" or "Very Poor." Given the opportunity to define a healthy community, one Key Informant stated that it should be "a community where individuals and families would choose to live [and one that can] provide a quality of life that is safe and engaged. People are being physically healthy, not being subject to lead poisoning and toxic things. Violence and noise pollution are not issues." Unfortunately, this community scenario is not widely available for the majority of Hartford residents, but community safety has multiple measures and Hartford experienced proportionally less crime than the state on infractions involving larceny/theft, gambling, liquor laws, and driving under the influence.

Figure 8. **Crime in Hartford and Connecticut (2009)**



In 1982, Wilson and Kelling introduced the broken windows theory to explain urban disorder and vandalism on crime and anti-social behavior [6]. The appearance of the environment can suggest what is acceptable, with a disordered environment implying that behaviors that are usually unacceptable can be perpetrated without fear of consequences. And although this theory has been met with criticism cities such as New York and Albuquerque have implemented policy shifts to address "quality of life" issues and have seen improvements in the overall community security and decreases in crime. Generally speaking, a safer community is synonymous with a healthier community.

Hartford has taken strides to address its issue with violence in the city. Since the re-instatement of the Shooting Task Force in 2011, shootings have decreased by 35% [7]. Although the partnership with neighboring cities, the Connecticut State Police, and the Office of the Attorney General has been effective in reducing shootings, a more comprehensive approach in crime intervention is needed. The City of Hartford is also making a concerted effort to improve the condition of its neighborhoods through the implementation of the Livable and Sustainable Neighborhoods Initiative. As part of this initiative, city government is partnering with homeowners and other neighborhood stakeholders throughout the city to address blighted properties and revitalize Hartford's sense of community. By addressing the needs of some of Hartford's most vulnerable areas, the city is taking proactive steps to rebuild its infrastructure, reduce crime, and restore hope.

Environmental Quality

The environment where we live, work and play; the quality of the air we breathe; the water we drink – all of these have an impact on our health. While individual education and behavior change are important to improving health, the real power in making progress on health is in changing the environment and systems that structure and affect our world.

The HEI measures the relative environmental burden of Connecticut's municipalities by using specific Federal Toxic Release Inventory data, examining levels of locally generated air and water pollution, and industrial density. These two measures are positively correlated with employment opportunities; however, they are however negatively correlated with health outcomes. Hartford receives an average score (4) in the Health Equity Index for both the number of facilities reporting and the total air emissions in pounds. Total water discharge and waste stream in pounds, measures of water pollution, are strong indicators of localized pollution levels, and Hartford has high levels of both. These two measures strongly correlated with the chlamydia and gonorrhea rates.

While potential relationships between high STD rates and a high environmental burden may initially seem attenuated at best, both act as a highly reliable indication of a marginalized neighborhood impacted by blighted property and compromised opportunities for fulfillment. Strong correlations between two seemingly distinct and independent realms such as environment and STDs speak to the vast array of various social and health burdens underserved communities bear disproportionately.

Civic Involvement

According to the HEI, Hartford receives the lowest possible score in terms of civic involvement. Civic involvement impacts health because it is a direct measure of social equity, activism and sustainability of a community; the HEI indicates a strong correlation of low civic involvement with infectious diseases, accident/violence, childhood illness, and life expectancy.

Table 7. **Health Indicators Related to *Civic Involvement***

	INDEX SCORE	CORRELATION COEFFICIENT
Infectious Disease	2	0.59
Accident/Violence	3	0.57
Childhood Illness	1	0.51
Life Expectancy	3	0.50
Mental Health	2	0.45
Cardiovascular	3	0.42
Health Care Access	2	0.42
Liver Disease	2	0.33
Renal Disease	2	0.32
Respiratory Illness	4	0.31
Diabetes	3	0.29
Perinatal Care	3	0.29

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Communities with demonstrated social cohesiveness are more likely to have greater resources and support networks, which would allow for improved health outcomes. Approximately 45% of Hartford's adult residents are registered to vote indicating that an inadequate proportion of the community selects state and municipal government officials. Several factors may prevent an individual from registering to vote including a lack of motivation, frustration with current leaders, or language or cultural barriers. In order to increase the number of registered voters, community-based education initiatives should be employed and should focus on demonstrating to individual residents that they are valued members of the community, and that their vote does in fact make a difference.

Community Food Security

Although not identified as a social determinant of health within the HEI, food security plays a vital role in urban settings like Hartford. While there are 14 medium and large grocery store retailers in the city, corner markets, convenience stores, and fast-food outlets are far more abundant, making a healthy diet difficult to maintain. Pre-packaged and prepared foods are more readily available at such establishments, and their lack of fresh and healthy foods can contribute to various poor health outcomes. In response to this deficiency, the City of Hartford, in partnership with farmers and community-based organizations, is working to

increase the number of farmers' market in the city. In 2011, there were 6 certified farmers' markets in the city accepting grant funds from the Women, Infants and Children federal program and its supplemental nutrition program, the Farmers' Market Nutrition Program. Furthermore, three of the markets were certified to accept Supplemental Nutrition Assistance Program benefits, which helped low-income people and families buy the food necessary for good health.

A report distributed by the University of Connecticut College of Agriculture and Natural Resources found that the presence of food retail resources were not significantly associated with community food security but income and lack of transportation that limit access to food are significantly associated. Despite high numbers of families enrolled in public food assistance, towns with greater rates of households headed by females or the elderly, or lack of education experience greater rates of food insecurity [8].

Foods that are highly processed contain both trans fats and refined sugars, and can lead to both diabetes and heart disease by increasing weight and cholesterol levels. The healthy food shopping choices available to Hartford residents are limited, and signal poor community health. More attention is needed for the overall food system components, including a greater focus on nutrition and cooking skills development.

VII. Health Indicators

As part of the assessment process, Key Informants were asked to rank the **five most significant health issues** in the City of Hartford. The respondents could choose from a list of 25 health issues as well as suggest their own that were not on the list. The five most identified – obesity, diabetes, mental illness, heart disease, and asthma – consisted of four health issues from the list and one write–in response.Mortality statistics are also noted in this section and infectious disease was included due in part to the unique age distribution of Hartford.

This section will also highlight how Hartford rates low in community health when compared to other Connecticut municipalities. As a result of its relatively low standing, this assessment focuses on a Hartford neighborhood comparative using city–specific indexing from the HEI in order to gain a richer understanding of city health concerns. The health outcomes included here are Life Expectancy, Mortality, Infant Mortality, Infectious Diseases, Respiratory Illness, Obesity/Heart Disease, Diabetes, and Mental Health.

Life Expectancy

Percent of deaths for the City of Hartford due to any of the top 10 causes of death in the U.S. are overall smaller when compared to the state and nation. The strongest positive determinant correlations with life expectancy are education, economic security, and civic involvement; with Hartford rating very low in each (HEI index of 2, 2, and 1, respectively).

Table 8. **Social Determinants of Health Related to *Life Expectancy***

	INDEX SCORE	CORRELATION COEFFICIENT
Education	2	0.64
Economic Security	2	0.61
Civic Involvement	1	0.50
Community Safety	1	0.41
Employment	3	0.35
Environmental Quality	4	0.34
Housing	3	0.31

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Table 9. **Top 10 Leading Causes of Death for Hartford, Connecticut and the U.S. (ranked from most to least common for Hartford; 2005-2007)**

	CITY OF HARTFORD	CONNECTICUT	U. S.
Heart Disease	**24.2%**	25.6%	25.4%
Malignant Neoplasms (Cancer)	**18.2%**	23.8%	23.1%
Accidents (Unintentional Injuries)	**5.5%**	4.2%	4.8%
Stroke (Cerebrovascular Disease)	**4.8%**	5.2%	5.5%
Chronic Lower Respiratory Diseases	**3.7%**	4.9%	5.3%
Diabetes	**3.4%**	2.6%	3.1%
Septicemia	**2.6%**	2.1%	1.4%
Influenza/Pneumonia	**2.4%**	2.9%	2.2%
Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Disease)	**2.3%**	1.9%	1.9%
Alzheimer's Disease	**1.2%**	2.6%	2.9%

However, the age-adjusted mortality rate (AAMR; defined as a death rate that controls for the effects of differences in population age distributions.) for all causes of death for the city is notably larger than that of the state and nation (876 compared to 692 and 778, respectively). With a younger population, this dramatic difference in the age-adjusted rate suggests that the mortality rate for older populations in Hartford is very high even though the elderly population itself may not be very large. Therefore, deaths due to heart disease and cancer low compared to the state and the U. S.

The Years of Potential Life Lost (YPLL; defined as an estimate of the average years a person would have lived if he or she had not died prematurely.) for Hartford was 10,647 per 100,000 for 2005-2007 for all causes of death. HEI scores Hartford 2 for YPLL. This measure correlated inversely with obtaining a bachelor's degree, and having a higher median household income and median value for owner occupied housing. It had a reverse effect for adults with less than a 9th grade education, so the lower level of education, the greater the years of potential life lost.

Infant/neonatal mortality is a major concern for Hartford; the mortality rates in Hartford for infants and neonates are markedly greater than those across Connecticut and the United States. Upon further examination, there is a pronounced disparity among infant deaths for infants of different races and ethnicities in Hartford; from 2001 through 2008, the mortality rate for Black infants was consistently higher than either the white or Hispanic infant mortality rate.

Figure 9. **Infant and Neonatal Mortality Rates* for Hartford, Connecticut, and the U.S. (2006)**

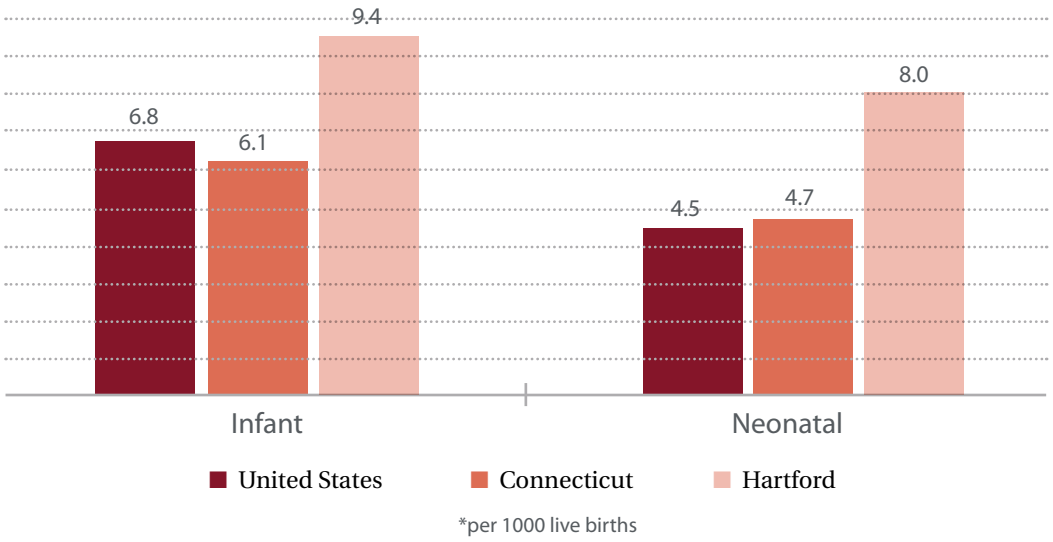
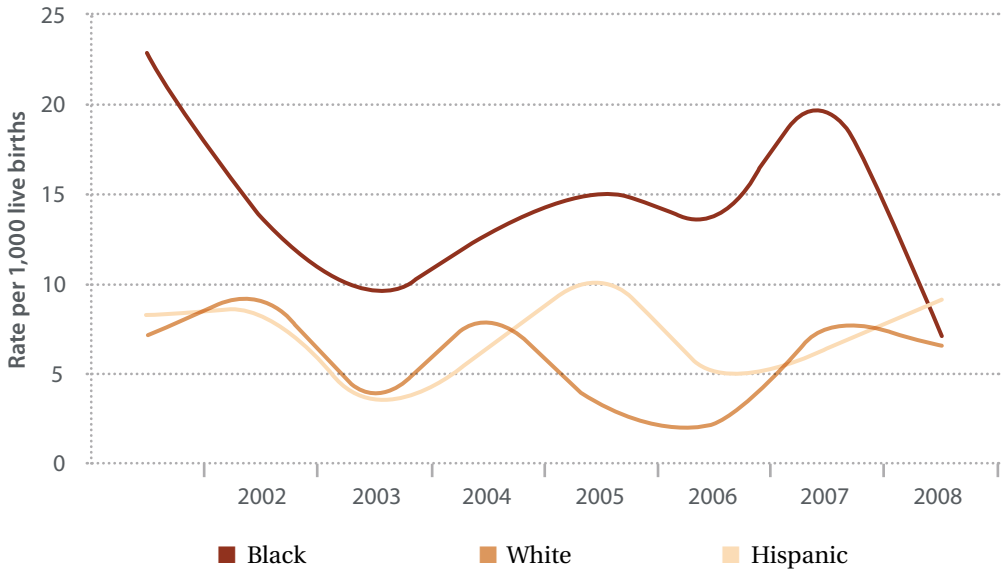
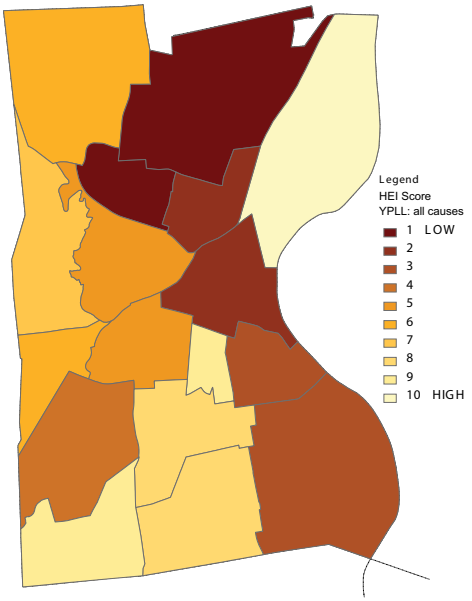


Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**



These adverse infant health outcomes greatly contribute to a lower than average life expectancy in Hartford. The following map highlights how its neighborhoods compare to each other with regard to the YPLL measure; the darker colors indicate a lower rating (greater number of years) for potential life lost. Six out of 15 neighborhoods (excluding the North and South Meadows neighborhoods) rated low on the YPLL. Per the HEI, the Northeast and Upper Albany neighborhoods were the lowest rated of all Hartford neighborhoods.

Map 3. **HEI Years of Potential Life Loss (YPLL) Score: All Causes by Neighborhood**



Infectious Diseases

In the state of Connecticut, there is a strong correlation of infectious disease with multiple social determinants, as demonstrated in Table 10.

Table 10. **Social Determinants of Health Related to *Infectious Disease***

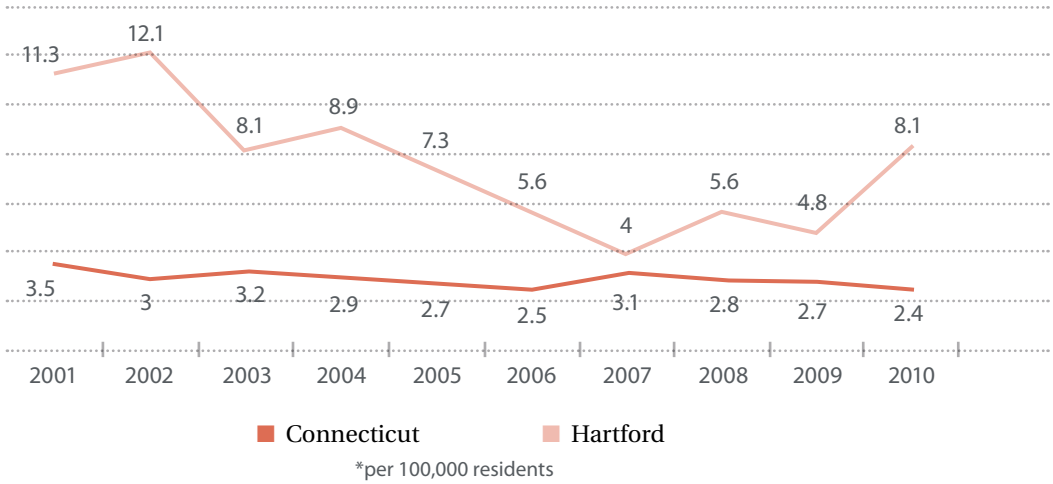
	INDEX SCORE	CORRELATION COEFFICIENT
Community Safety	1	0.67
Education	2	0.59
Environmental Quality	4	0.59
Civic Involvement	1	0.59
Economic Security	2	0.58
Housing	3	0.55
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

There is particular concern when examining **HIV** trends in the city. From 2002 through 2009 per the Connecticut Department of Public Health HIV Surveillance Program, the number of HIV infection cases declined for the city; however, there has been a 221% increase of new HIV infections among self-reporting men who have sex with men over the same time period, as well as a 123% increase in new infections amongst Hartford's Black residents.

There is an established correlation between HIV rates and rates of tuberculosis infection [9]; however, that does not seem to be the case in Hartford. Data from the Connecticut Department of Public Health's Tuberculosis Control Program shows that while tuberculosis rates in Connecticut are in decline, tuberculosis rates in Hartford are increasing.

Figure 11. **Tuberculosis Prevalence* in Hartford and Connecticut (2004-2010)**



The Connecticut Department of Public Health's STD Control Program provides information on infections more commonly associated with reproductive health. From 2007-2010, a total of 7768 cases of **chlamydia** were reported in Hartford (rate of 157 per 10,000 residents), which is almost 1.5 times higher than the next highest rate of chlamydia infection in the state. Among Blacks and Latinos, the rates were 12.1 and 5.3 times higher than those for whites, respectively. Of all the diagnoses reported during this period, approximately 70% of the cases were among 15 to 24-year olds; Black and Latino female adolescents and young adults accounted for about 36% and 20%, respectively, of all reported chlamydia cases during this same period.

Gonorrhea is the second most commonly reported STI in Hartford after chlamydia. Between 2007 and 2010, approximately 20% of the total reported cases of gonorrhea in the state occurred in Hartford (a rate of 40.5 per 10,000 residents). The rate of infection of women when compared to men was 1.5 times higher (119 versus 78 per 10,000 residents, respectively). Blacks and Latinos also had a disproportionate rate of infection when compared to whites (15.3 and 4.1 times greater, respectively); infection rates were also the highest for 15- to 24-year olds.

Since 2008 the prevalence of **syphilis** in Hartford has increased from 4.1 to 10.5 cases per 100,000 residents; and approximately 94% of all reported cases were male. A racial and ethnic disproportion is also reflected, as African American and Latino male rates were 9.2 and 4.3 times higher than white males, respectively.

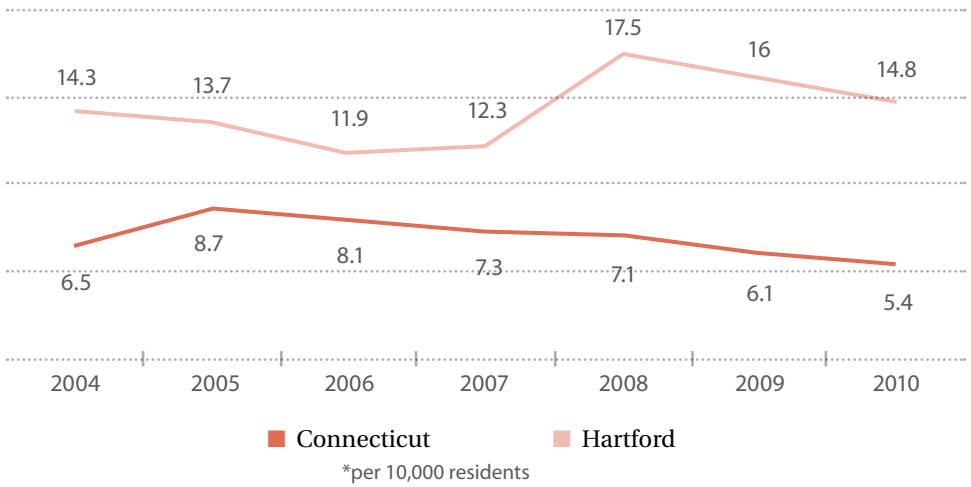
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

	PERCENT INFECTED
15-24 years old	34%
25-34 years old	10%
35-44 years old	41%

During this same time period, syphilis prevalence among males 25-34 year old increased 81% to 32 cases per 100,000; and among males 35-44 years old it increased 51% to 79 cases per 100,000.

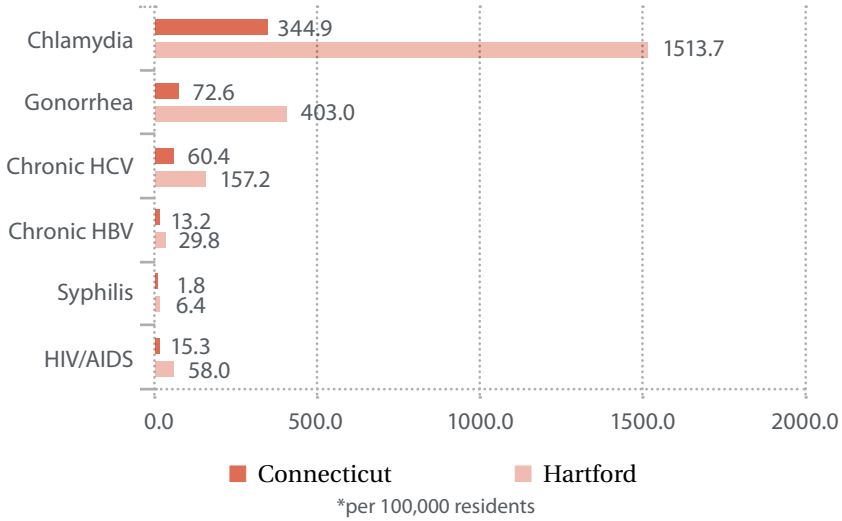
The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



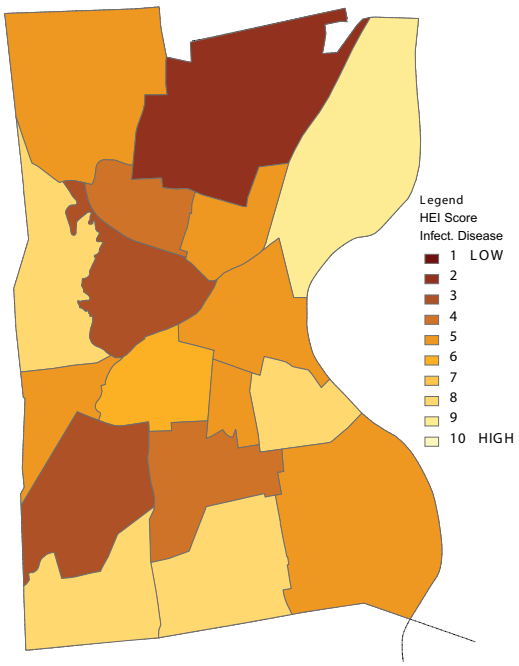
With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

Figure 13. **Infectious/Communicable Diseases Prevalence* in Hartford and Connecticut (2009)**



Using data from Connecticut's Department of Public Health, a comparison of how Hartford's neighborhoods compare to each other with regard to infectious diseases is demonstrated in the following map using the same HEI rating system; the Northeast rated lowest out of 17 total neighborhoods.

Map 4. **HEI Infectious Disease Score by Neighborhood**



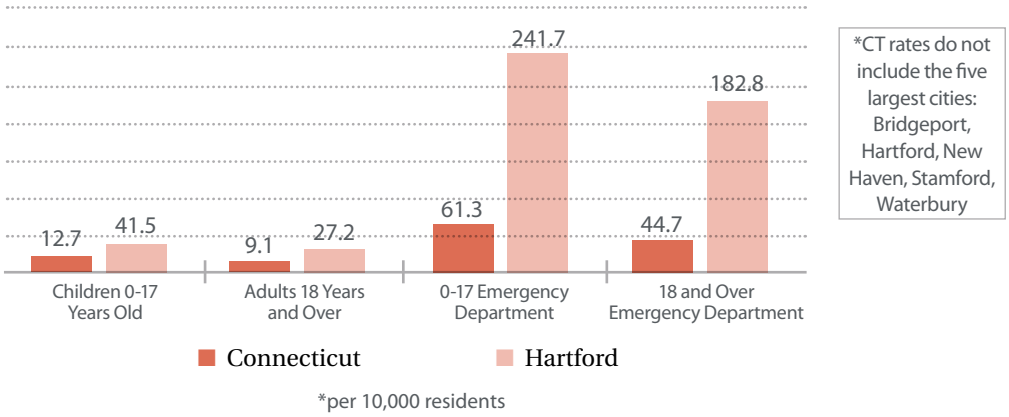
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

The Department of Health and Human Services and the Consortium can identify the prevalence of infectious diseases and provide resources to those who are in most need. The Department's division of Disease Prevention and Health Promotion has both an STD and TB clinic, as well as an HIV program, all geared to curtail infection rates and keep Hartford residents informed and educated. The federal government has passed legislation that provides for individuals who live with HIV/AIDS affordable, high-quality HIV care and related services. For those who are already established Ryan White consumers, there is a network of agencies and area providers that are connected to the city and in position to provide needed services and resources.

Respiratory Illness

Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

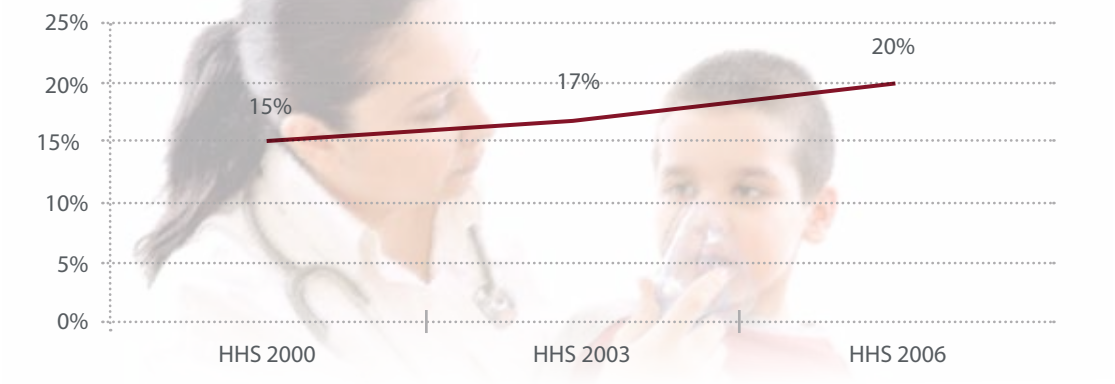
Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**



*per 10,000 residents

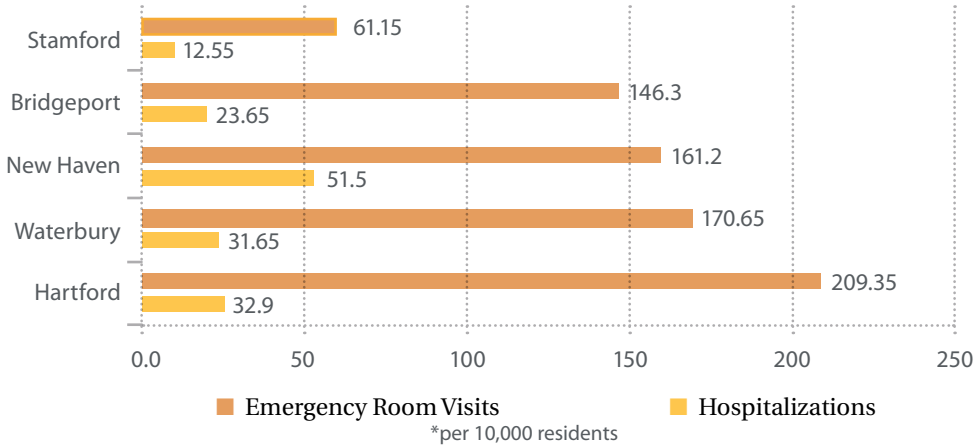
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

Figure 15. **Percent of Self-Reported Asthma from Hartford Health Survey (2006)**



Regardless of how residents self-report, Hartford has the highest rate of emergency room usage (209 ER visits for every 10,000) and the second highest rate of hospitalization for asthma as the primary cause of diagnosis (33 admissions per 10,000) when compared to other major Connecticut cities.

Figure 16. **Asthma Hospitalizations and Emergency Room Visit Rates* for All Residents by Connecticut City (2001-2007)**



Similar to asthma hospitalization rates, mortality rates are also an area of concern when compared to the rest of the state. The asthma-related mortality rate for men in Hartford is 22.4 per 10,000 men compared to 7.9 for the rest of Connecticut. Similarly, the mortality rate for women in Hartford is 42.5 compared to Connecticut's rate of 16.5.

In general, respiratory illness in Hartford has some moderate correlations, as noted in the following table, but the HEI indexed score is very low for each of the social determinants correlated to respiratory illness.

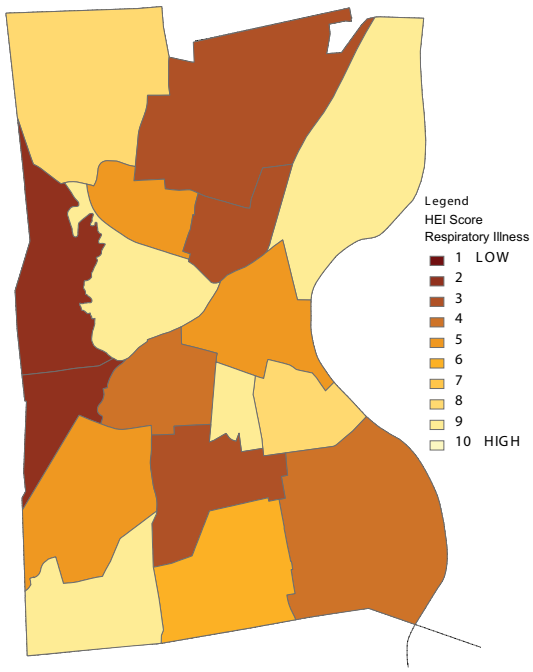
Table 12. **Social Determinants of Health Related to *Respiratory Illness***

	INDEX SCORE	CORRELATION COEFFICIENT
Economic Security	2	0.45
Education	2	0.41
Civic Involvement	1	0.31
Housing	3	0.29
Employment	3	0.28
Community Safety	1	0.26
Environmental Quality	4	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Using Connecticut Department of Health Office of Vital Records data, the HEI scores Hartford an overall indexed score of 4 when compared to other Connecticut towns and cities. The following map gives an indication of where the lowest scores lie when comparing among Hartford's neighborhood; the West End and Parkville neighborhoods ranked the lowest among Hartford neighborhoods with regard to respiratory health.

Map 5. **HEI Respiratory Illness Score by Neighborhood**



To help address these issues, the Asthma Call to Action Taskforce, a coalition of representatives from Hartford's Department of Health and Human Services, public schools, area hospitals, community organizations, and other agencies that are concerned about asthma in Hartford, seek to increase awareness about asthma to its residents, improve asthma care, establish a network of individuals and organizations to provide education and resources, and define asthma rate improvement strategies.

Obesity and Cardiovascular Disease

The percentages of obese Connecticut adults 20 years and older are notably higher for the Black and Hispanic populations (39.8% and 29%, respectively) than the state's white population (20.6%) [10]. Obesity is most commonly measured as a percentage of body fat based on height and weight. The following table shows the percent of healthy, overweight, and obese adults in the UnitedStates for all income levels as determined by the National Health and Nutrition Examination Survey. These weight category trends are similar when looking solely at people who are classified as "poor" (those who lived below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22, 314 for a family of four) by the US government. With a high rate of unemployment and a low HEI ranking for economic security, it can be assumed that obesity trends in Hartford are similar and that there is an increased relative risk for hypertension and adverse cardiovascular outcomes [11]."

Table 13. **United States Weight Categories**

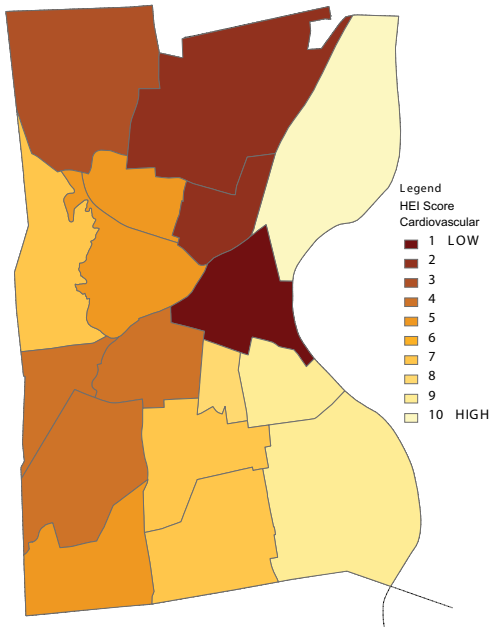
	HEALTHY WEIGHT	OVERWEIGHT	OBESE
1988-1994	41.9%	33.0%	22.7%
2001-2004	32.4%	34.7%	31.2%
2005-2008	30.9%	33.5%	33.9%

Similar rates emerge when looking at people who are classified as "poor" by the US government (those who live below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22,314 for a family of 4). With high rates of unemployment and a low HEI rating for economic security in Hartford, this trend is most likely mirrored in the city.

Downtown, the neighborhood with the lowest residential density, has the highest economic security and education scores, as well as the largest proportion of white residents. Despite such a low percentage of Hartford residents living Downtown, the fact that this population enjoys greater employment as well as health care coverage contributes to an increase in cardiovascular diagnoses and ultimately prevents undesirable health outcomes. For the remainder of Hartford's residents, cardiovascular health indicators remain elusive.

Obesity has been linked to both cardiovascular health and diabetes [12], and heart disease was the leading cause of death for Hartford from 2005 to 2007. The Northeast and Frog Hollow neighborhoods rate the poorest for these two significant risk factors.

Map 6. **HEI Cardiovascular Disease Score by Neighborhood**



There are several strong and moderate correlations with cardiovascular health, the top being education and economic security; below is a table listing the top five.

Table 14. **Social Determinants of Health Related to *Cardiovascular Health***

	INDEX SCORE	R_S VALUE
Education	2	0.51
Economic Security	2	0.48
Civic Involvement	1	0.42
Environmental Quality	4	0.36
Community Safety	1	0.33
Housing	3	0.29
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Diabetes

The fact that diabetes often presents as a co-morbidity with other diseases, it is difficult to segregate the information for just diabetes. The following table shows the age-adjusted percentages for adults 20+ for selected ethnic groups throughout the state; the data are from the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS).

Table 15. **Connecticut Residents with Diabetes by Race**

YEAR	ALL ADULTS	NON-HISPANIC WHITE	NON-HISPANIC BLACK	MEXICAN-AMERICAN
2005	7.2%	6.6%	14.3%	15.1%
2006	6.9%	6.4%	15.0%	10.4%
2007	8.3%	7.1%	20.4%	13.5%
2008	7.2%	6.2%	16.1%	11.6%
2009	6.8%	6.4%	13.0%	9.7%
2010	7.6%	7.0%	13.9%	9.5%

The rates are alarmingly higher for non-Hispanic Blacks, and Hispanics; these trends are the same across all economic levels, and substantially higher for those who live below and near the poverty threshold. Since 2007, there has been a significant improvement in these high rates as both the Black and Hispanic populations in the state have experienced a drop in the rate of diabetes, but there is still a diabetes health disparity drawn along racial lines for the state.

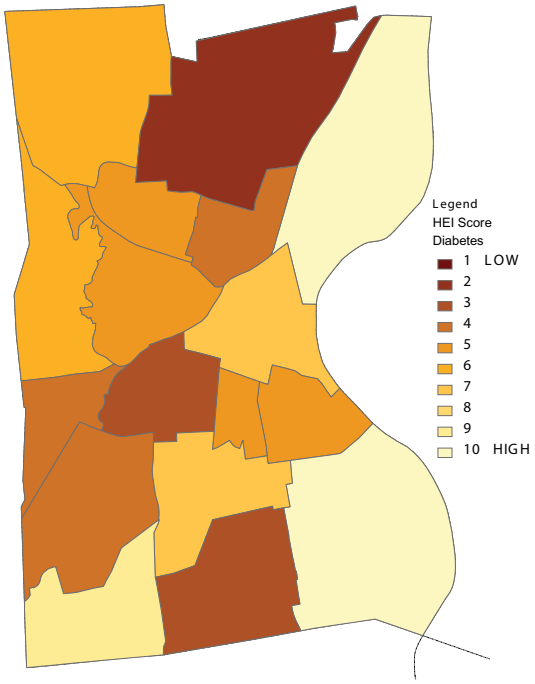
While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared to other racial/ethnic groups.

Figure 17. **Diabetes in Hartford for Adults**

Source: US Dept of Health and Human Services, The Office on Women's Health

The neighborhoods are compared to one another in the following map using the HEI indexing giving an indication where in Hartford diabetes is more of a health issue. The Northeast neighborhood ranks the lowest among Hartford neighborhoods.

Map 7. **HEI Diabetes Score by Neighborhood**

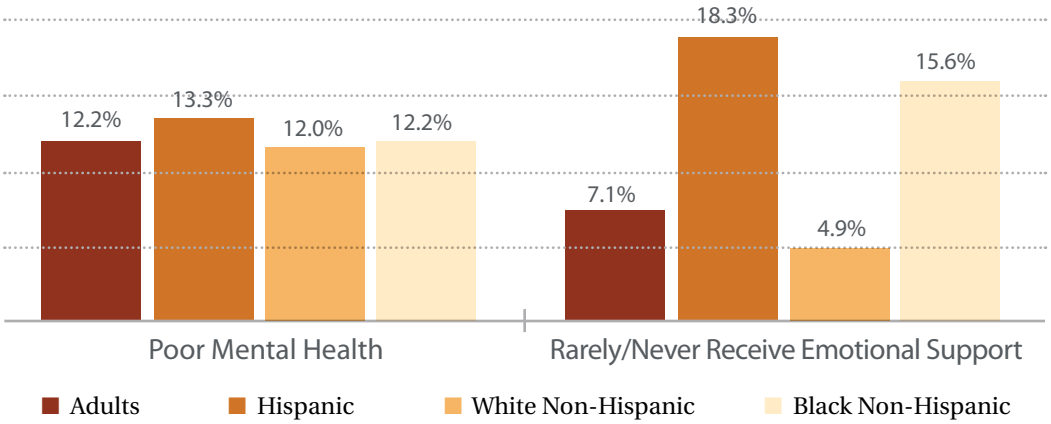


Behavioral Health

The HEI, using discharge data from the Connecticut Hospital Association and death information from the Connecticut Office of Vital Records, calculated an aggregate index score of 2 for mental health as a health indicator for Hartford. There are several significant correlations with mental health, including community safety (Rs=0.55), economic security (Rs=0.47), environmental quality (Rs=0.45), civic involvement (Rs=0.45), education (Rs=0.42), housing (Rs=0.37), and employment (Rs=0.23). With a low-indexed social determinant score, it can be inferred mental health issues are a significant health risk for the city. The BRFSS, a national system of state-based surveys, annually assessed how the residents fare with mental health issues. The results show that there is clearly a greater rate of Hispanics and Blacks self-reporting a lack of emotional support.

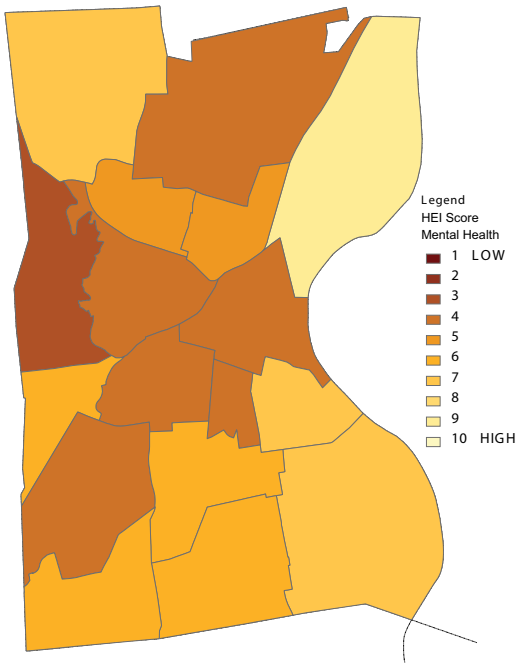
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for a more thorough investigation and coordinated approach. HHS is currently engaged in a collaborative partnership that includes planning for a Behavioral Health Needs Assessment in order to fully understand the nature of these services.

Figure 18. **Mental Health in Connecticut (Age Adjusted; 2007-2009)**



The neighborhood with the highest utilization of mental health services is the West End, which happens to be relatively affluent when compared to other city neighborhoods. The Consortium could hypothesize that individuals with greater access to specialized health care services would experience higher rates of diagnoses.

Map 8. **HEI Mental Health Score by Neighborhood**



VIII. Barriers to Services

The Urban Alliance survey asked respondents to consider barriers to health services and community resources. The most commonly reported barriers to service areas included not knowing about existing services (27%), lack of available services (22%), not able to pay (20%), and lack of transportation (20%).

Respondents were also asked to identify the most crucial **perceived service needs** for Hartford. Areas perceived as the most in need of additional services included homelessness/ housing (45%), education (41%), job training/employment assistance (39%), and basic needs/food assistance (36%). The top **actual service needs** were determined by respondents indicating that someone in their household would benefit from having additional service in this area. This resident survey found that the actual needs of the respondents were, for the most part, similar to the perceived needs of Hartford; three of the top five needs mentioned were common to both (see table below; ranked by most common responses and common responses bolded). The two areas - perceived and actual service needs - were explored separately to note differences, but with such high correlations in Connecticut between employment, education, and housing, as well as other factors, the overlap between the two areas is not as discordant as they appear to be.

Table 16. **Top 5 Needs for Hartford**

ACTUAL NEEDS	PERCEIVED NEEDS
Basic needs/food assistance services	Homelessness/housing
Financial support services	Education
Job training/employment assistance	Job training/employment assistance
Health and wellness	Basic needs/food assistance
Education	Youth development

The Key Informant interviews completed by the Consortium had similar findings. More than half of Key Informants chose either "Disagree" or "Strongly Disagree" with positive statements about access to care regarding dental services, medical specialists, a comprehensive model of primary care, providers who accept Medicaid, transportation, and health care delivery in Hartford.

Table 17. **Key Informant Perceptions of Health Care**

ACCESS/ BARRIERS TO CARE	"DISAGREE" OR "STRONGLY DISAGREE"
The majorities of Hartford residents are able to access and afford a dentist when needed.	88%
The majority of Hartford residents are able to access needed medical specialists.	83%
The majorities of Hartford residents are able to access and afford a primary care provider.	76%
Transportation to medical appointments is available to residents when needed.	73%
The healthcare delivery system in Hartford has a comprehensive approach to patient care.	71%
There is a sufficient number of providers accepting Medicaid or other forms of medical assistance.	70%
There is a sufficient number of bilingual healthcare providers in Hartford.	63%

IX. Conclusions

This Community Health Needs Assessment was assembled to give readers an overview of Hartford public health trends and to provide a platform to increase the communication across non-governmental as well as governmental agencies to improve the lives of city residents. The findings from this process demonstrate that Hartford residents include high concentrations of people at an increased risk for unhealthy living. After examining all the data sources used to create this report – the Key Informant Survey, the Hartford Survey Project, and the various secondary data that were analyzed – it is clear that marginalized and underserved populations are overrepresented in the city, and the need for establishing and expanding effective partnerships among city agencies is critical. Poverty, job opportunities, education, quality of housing, and neighborhood safety are quality of life measures that were most often mentioned by the Key Informants. All of these were highlighted in the data as areas where collaboration and renewed effort are necessary.

According to a recent model created by the University of Wisconsin's Population Health Institute, at least half of community wellness is driven by non-health factors such as education, housing, and pollution [13]. Connecticut, consistently one of the wealthiest states in the union, is also home to some of the nation's most significant gaps in leading societal determinants of health. For instance, when looking at poverty, Latinos are 4.7 times and Blacks are almost 3.6 times more likely to be living in poverty when compared with their white counterparts in Connecticut. These poverty rates among Black and Latino population reflect, in part, the terribly high unemployment rates in cities like Hartford, which have been crippled by unemployment rates at least 50% higher than that of the state. Coupled with things like a high percentage of single parent households with children present, these compromising circumstances make it difficult for Hartford residents and their families to achieve optimal health.

In addition to a high concentration of poverty, this assessment identifies other actionable non-medical factors that drive the state of health in Hartford. **Education**, for example, is a key indicator for economic security; low educational attainment coupled with limited employment opportunities adversely impact economic security of the city on a whole. Hartford's battle is a difficult one as one-third of Hartford adults do not have a high school diploma. And with one-fifth of the city's labor force unemployed and a high rate of service occupations for those who are employed, it is apparent that when people get off on the wrong foot, the path to occupations with increased responsibility and higher wages become all the more difficult.

The **housing** situation in Hartford makes it difficult to find up-to-date accomodations. The housing stock in Hartford is an aging one, where more than half of the housing available for both renters and buyers was built prior to 1950. And of all the housing occupied, less than a quarter of Hartford residents own their domicile; the majority has to choose from these old housing options.

Crime continues to be a problem in Hartford. With such a high number of youth living in the city, there is going to be an increased rate of violent and injury-related deaths. The city, having about 3.5% of the entire state's population, accounts for more than a third of all murders. In addition, there are some very specific health issues that should be highlighted:

- High age-adjusted mortality rates despite a population that is relatively young suggest that the senior population is dying at a high rate
- The diabetes rate, although well below Connecticut's rate, has climbed steadily in recent years
- As a percent of the total population in Hartford, residents who are obese are increasing while the percent of healthy weight adults declines
- The infant mortality rate in Hartford is much higher than Connecticut and the United States

Preventing problems before they arise is a particularly powerful tool in population health. These prevention efforts will result in a dramatic cost savings and reduction in social problems to our community. In 2009, the Mayor's office in collaboration with HHS designed and launched the Healthy Hartford wellness campaign, focused on many aspects of daily life in our urban environment. The goal of this campaign is to increase the availability of health related information and have community discussions designed to influence the choices that the Hartford citizenry at all ages makes regarding health behaviors like physical activity, proper eating, and other aspects of disease prevention. HHS launched a set of creative teams to design high-impact activities and approaches targeting all residents; the Healthy Hartford campaign was recently recognized by the U.S. Surgeon General and received the *Healthy Youth for a Healthy Future Champion Award* for its efforts to curb and prevent childhood overweight and obesity within our community. The Healthy Hartford campaign along with its many partners strives to reach the largest possible number of residents by designing interactive activities that target specific demographic groups throughout Hartford's 17 neighborhoods.

The Healthy Hartford campaign is a collaborative effort with area health providers and organizations to promote healthy choices and solutions to health problems by focusing efforts on a specific segment of the population or aspect of living in Hartford (i.e., youth, women, and men; Hartford workforce; and public policies that affect the health of the people). As an example, the recently formed Hartford Childhood Wellness Alliance draws on the combined leadership and expertise of community and professional groups across a spectrum of public health, medicine, academia, child care, and recreation to address the critical issue of childhood health and weight in Hartford. The Alliance provides a structure through which individuals and organizations can join together in the common interest of creating healthy environments for children and families, which in turn would be a cost saver to the city. Early in 2011, the Society of Actuaries calculated that the total economic cost of overweight and obesity in the United States is $270 billion per year as a result of an increased need for medical care, loss of worker productivity due to higher rates of death, loss of productivity due to disability of active workers, and loss of productivity due to total disability. Providing increased accurate chronic

disease self-management training to Hartford residents would have a positive impact on total cost to the city.

Collaboration holds the promise of allowing progress on issues where multiple parties are involved. Sustaining collaborations in Hartford is possible not only because of established partnerships but also because of efforts like such as this needs assessment, which will further strengthen existing relationships by highlighting where the major needs are. Any local health department is limited by available resources. Therefore, HHS' standard operating procedure is to constantly search for, and partner with, other organizations in order to better the lives of Hartford's citizenry.

The Public Health Advisory Council, a city charter-supported advisory panel, is an example of a sustained collaboration relative to residential health and chronic disease. Members of the panel include high-level representation from area hospitals, the Hispanic Health Council, the State of Connecticut Department of Mental Health and Addiction Services, the Connecticut Association of Directors of Health, and other community health organizations, and has regularly met for approximately the last 15 years. As experts on community health, the Public Health Advisory Council advices the city on many public health policies and initiatives.

In order to have improved collaborations throughout the city, there needs to be better data exchange among health organizations. Both health and societal data are not consistently collected, are difficult to compare longitudinally, and frequently may not tell the whole story. To improve the health of Hartford residents, HHS and its partners must have access to accurate local data. There are opportunities to make significant improvements in gathering and tracking such data on all of these issues, particularly on the issues of chronic diseases and risk factors that contribute to health disparities. It is imperative that those working in public health and providers of direct clinical services collaborate to develop a strategic plan for delivery of health care (including preventive care and mental health services) in a manner best suited to the community being served.

This report has presented a case that trends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services. Rather, these rates are a result of but also social, political, and environmental conditions. At the population level, major influences on health are structural. Throughout the development of this report, it has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services, a result of cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.

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XI. Appendix

A. Agencies that participated with the Key Informant Interviews:

Alcohol and Drug Recovery Centers, Inc.	Family Life Education
Asian Family Services (CRT)	Gay and Lesbian Health Collective
Blue Hills Civic Association	Greater Hartford Interdenominational Ministerial Alliance, Inc.
Boys and Girls Clubs	Greater Hartford Interfaith Coalition for Equity and justice
Cancer Program at Hartford Hospital	Hartford 2000
Capital Workforce Partners	Hartford Behavioral Health
Capitol Region Education Council	Hartford Community Schools
Casey Family Services	Hartford Foundation for Public Giving
Catholic Charities (Archdiocese of Hartford)	Hartford Hospital
Catholic Worker House	Hartford Office of Youth Services
Charter Oak Health Center	Hartford Public Schools
Child Health and Development Institute of Connecticut, Inc.	Hispanic Health Council
Children's Trust Fund	Immaculate Conception Shelter and Housing Corp.
Clay Arsenal Neighborhood Revitalization Zone	Injury Prevention Center at CCMC
Commission on Children	Institute for Community Research
Community Health Service	Institute for Hispanic Families s
Community Renewal Team, Inc. (CRT)	Interval House
Conference of Churches	Khmer Health Advocates
Connecticut Children's Medical Center (CCMC)	Latino Community Services
Connectikids	Malta House of Care, Inc.
CT African-American Affairs Commission	My Sister's Place
CT Association of Directors of Health (CADH)	Office for Young Children (COH)
CT Association of Human Services	Pediatric Clinic at Saint Francis Hospital
CT Coalition for Environmental Justice	Saint Francis Hospital
CT Department of Mental Health and Addiction Services	The Village for Families and Children
CT Department of Public Health	UConn Health Center
CT Department of Social Services	UConn School of Social Work
CT Voices for Children	United Way
Daughters of Eve	Urban League of Greater Hartford
Department of Community Outreach at Saint Francis Hospital Wellness	Easy Breathing at the Hartford Alliance for Childhood
Emergency Department at Hartford Hospital	Women's League Child Development Center

B. Key Informant Survey

City of Hartford 2010 Key Informant Survey

Good morning/afternoon, my name is _____ and I'm calling on behalf of the City of Hartford Department of Health and Human Services, CCMC, Saint Francis Hospital and Hartford Hospital. You should have received a letter from those institutions soliciting your participation in a brief survey that is part of a community needs assessment for the City of Hartford. You should have received a survey in advance to help us in this process; if that is not the case I could send one now and schedule for a latter time.

Do you have approximately 15-20 minutes to complete the survey with me? If not, I would be glad to schedule a time that is convenient with your schedule and call you back.

Please know that all of your responses will be held in strict confidence. No individual from the sponsoring organizations will have access to your individual survey. I'd like to emphasize that I am not an employee of the City of Hartford, but am affiliated with Holleran, a research firm located in Lancaster, Pennsylvania commissioned to conduct this research.

DEMOGRAPHICS

Area of Expertise:
Education Level:
Years providing services:

1. What is your vision of a healthy community?

2. What are the most significant barriers that residents of Hartford face when they attempt to access healthcare?

3. What specific populations in Hartford do you feel are not being adequately served by the healthcare system?

_____

_____

_____

4. In your opinion, what proportion of the population in Hartford views the hospital emergency room as their key source of primary care? _____%

Key Health Issues

1. In your opinion what are the five most significant health issues (most severe or most serious) you perceive in your community. The first one being the least important and the last one being the most important.

Caller: Read the list only if respondent needs prompting.

☐ Diabetes	☐ Substance Abuse
☐ Cancer	☐ Mental Illness
☐ Heart Disease	☐ Domestic/Family Violence
☐ Stroke	☐ Abuse of Children
☐ Obesity	☐ Sexually Transmitted Diseases – does not include HIV/AIDS
☐ Daily Life Stressors	☐ HIV/AIDS
☐ Reproductive Health	☐ Violence

Other _____

2. In your opinion what would be the best way to promote health prevention and wellness?

3. Regarding health and well-being, what needs of Hartford residents are currently begin met the best?

4. Regarding health and well-being, what would you say are the greatest unmet needs among residents of Hartford?

5 If you had to identify two key improvements that you feel are needed to provide better healthcare for area residents, what would they be?

a. _____
b. _____

Comments regarding Key Health Issues:

_____
_____
_____
_____

Quality of Life

1. On a scale of 1 (very poor) through 5 (excellent), please rate each of the following within the community.

1 = very poor; 2 = poor; 3 = average; 4 = good; and 5 = excellent.

NEIGHBORHOOD/ENVIRONMENT	Very poor « » Excellent
a. Availability of recreational activities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. Neighborhood safety	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. Clean, litter-free neighborhoods	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. Water or air pollution	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Quality of housing (affordable, in good condition)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. Road/traffic conditions	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
g. Schools/education	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
h. Job opportunities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
i. Availability of care for children	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
j. Poverty	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Quality of Life or any example that illustrates your answers:

2. What specific suggestions do you have for area hospitals and public health agencies to improve the quality of life in the community?

Quality of Care

1. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements.

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

HEALTHCARE	Strongly disagree « » Strongly agree
a. There are a sufficient number of bilingual providers in Hartford.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in the area are able to access a primary care provider.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. The majority of residents in the area are able to access a medical specialist.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The majority of residents in the area are able to access a dentist when needed.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Transportation for medical appointments is available to the majority of residents.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Healthcare or any example that illustrates your answers:

SOCIAL SERVICES	Strongly disagree « » Strongly agree
a. The majority of the residents in Hartford would know where to go if they needed mental health/ behavioral health treatment.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in Hartford would know where to go if they needed help with a substance abuse problem.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. There are a sufficient number of behavioral health providers in the area.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The healthcare delivery system in Hartford has a holistic approach to patient care?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Social Services or any example that illustrates your answers:

That concludes the survey. Thank you very much for your time today and we appreciate your feedback!

C. Hartford Resident Survey: English

URBAN ALLIANCE

HARTFORD RESIDENT SURVEY

URBANALLIANCE

You are being invited to complete this survey because you are a Hartford resident. We are interested in learning about services that would be helpful to you and your family as well as barriers to receiving these services. It is our hope that the results of this survey will enhance and increase services offered in the city of Hartford.

QUESTIONS ABOUT YOU

This survey begins with questions about you and your family. These help us to describe who completed the survey.

1. Do you live in the city of Hartford?
☐ Yes ☐ No
*Please provide your Zip Code:*_____

2. What is your ethnicity?
☐ Latino ☐ West Indian ☐ Multi-ethnic
☐ White ☐ African ☐ Other
☐ Asian American *Specify:*_____

3. What is your gender? ☐ Female ☐ Male

4. Do you attend a church?
☐ Yes *If yes, please specify which church:*
☐ No _____

5. How many adults live in your household? _____

6. How many children live in your household?_____

7. Check the box that best describes your age:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

QUESTIONS ABOUT SERVICES IN HARTFORD

*In the **first column (questions a & b),** indicate if you or someone in your household (someone who lives with you) would benefit from additional services in each area and barriers to receiving each type of service.*

*In the **second column (question c),** rank (1 through 3) the three areas most in need of additional services in the city of Hartford. Place the ranking in the box corresponding to each service area (1 indicates the area most in need of additional services). Complete this column after you have completed the first column (questions a & b) for each type of service.*

1. SUBSTANCE ABUSE RECOVERY *(e.g. treatment, prevention)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access substance abuse recovery services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

2. BASIC NEEDS/FOOD ASSISTANCE *(e.g. food pantry, meals, clothing, utility assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access basic needs/food services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

3. HOMELESSNESS/HOUSING *(e.g. emergency shelter, affordable housing)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access housing services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

4. COUNSELING/EMOTIONAL SUPPORT *(e.g. counseling, support group, stress management)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access counseling/emotional support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

5. YOUTH DEVELOPMENT *(e.g. leadership training, mentoring, after-school programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access youth development services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

6. HEALTH AND WELLNESS *(e.g. health care, screenings)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access health and wellness services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

7. EDUCATION *(e.g. tutoring, GED classes, ESL, literacy)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access education services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

8. FINANCIAL SUPPORT SERVICES *(e.g. personal finance planning, financial literacy, tax preparation)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access financial support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

9. ELDERLY SERVICES *(e.g. convalescent home, meals, senior center/programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access services for seniors? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

10. PRISONER /RE-ENTRY SERVICES *(e.g. visitation, re-entry assistance, support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access prisoner/re-entry services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

11. JOB TRAINING/EMPLOYMENT ASSISTANCE *(e.g. skill development, resume assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access job training/employment services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

12. PREGNANCY/PARENTING SUPPORT *(e.g. parenting/prenatal education and support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access pregnancy/parenting support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

c. Rank the three areas most in need of additional services in Hartford ☐

D. Hartford Resident Survey: Spanish

ALIANZA URBANA
ENCUESTA SOBRE RESIDENTE HARTFORD

Usted está invitado a terminar esta encuesta porque usted es un residente de Hartford. Estamos interesados en aprender sobre los servicios que le serían provechosos a usted y su familia así como barreras para recibir estos servicios. Nuestra meta es mejorar y aumentar el alcance de los servicios ofrecidos en la ciudad de Hartford.

PREGUNTAS DE USTED

Esta encuesta comienza con preguntas sobre usted y su familia y nos ayudan a describir quién terminó la encuesta.

1. ¿Usted vive en la ciudad de Hartford?
☐ Sí ☐ No
*Proporcione por favor su Código postal:*_____

2. ¿Cuál es su pertenencia étnica?
☐ Latino ☐ Oeste Indio ☐ Multi-étnico
☐ Blanco ☐ Africano ☐ Otro
☐ Asiático Americano *Especifique*:_____

3. ¿Género? ☐ Femenino ☐ Masculino

4. ¿Usted asiste a alguna iglesia?
☐ Sí *Especifique por favor qué iglesia:*
☐ No _____

5. ¿Cuántos adultos viven en su casa? _____

6. ¿Cuántos niños viven en su casa?_____

7. ¿Está entre las edades de?:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

PREGUNTAS SOBRE SERVICIOS EN HARTFORD

*En la **primera columna** (preguntas a y b), indique si usted o alguien en su hogar serían beneficiado por servicios adicionales en cada área y también indique las barreras para recibir cada tipo de servicio.*

*En la **segunda columna** (pregunta c), Marque (1 a 3) las tres áreas más necesitadas de servicios adicionales en la ciudad de Hartford. Marque la caja que corresponde a cada área de servicio (1 indica la área más en necesidad de servicios adicionales). Termina esta columna después de que usted haya terminado la primera columna (preguntas a y b) para cada servicio.*

1. RECUPERACIÓN DEL ABUSO DE LA SUSTANCIA *(e.g. tratamiento, prevención)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de recuperacion del abuso de la sustancia?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguística	☐ Sin seguro medico
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	☐ Otro:

c. Marque las tres areas más necesitando adicional servicios ☐

2. NECESIDADES BASICAS/ASISTENCIA DE ALIMENTOS *(e.g. despensa de alimento, ropa, ayuda para utilidades)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de necesidades basicas/asistencia de alimentos?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	_____

c. Marque las tres areas más necesitando adicional servicios ☐

3. PERSONAS SIN HOGAR/VIVIENDA *(e.g. abrigo de emergencia, cubierta comprable)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de personas sin hogar/vivienda?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	_____

c. Marque las tres areas más necesitando adicional servicios ☐

4. ASESORAMIENTO/APOYO EMOCIONAL *(e.g. asesoramiento, grupo de ayuda)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de asesoramiento/apoyo emocional?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de ninos	☐ Falta de transporación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera linguistica	☐ Sin seguro medico
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos economicos	☐ Otro:

c. Marque las tres areas más necesitando adicional servicios ☐

5. DESARROLLO DE LA JUVENTUD *(e.g. programas después de la escuela)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de desarrollo de la juventud?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

6. SALUD Y BIENESTAR *(e.g. cuidado médico, examenes)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de salud?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos ☐ Otro:

c. Marque las tres areas más necesitando adicional serivicios ☐

7. EDUCACIÓN *(e.g. tutoria, GED, ESL)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

¿Qué factores hacen difícil de tener acceso a sevicios de educación?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

8. SERVICIOS DE APOYO FINANCIERO *(e.g. preparación de impuesto, planificación financiera)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

9. SERVICIOS ENUEJECIENTES *(e.g. clínica de reposo, comidas, centro mayor/programas)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de enuejecientes?

☐ **Nunca henecesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

10. SERVICIOS DE PRISIÓN Y DE REINTEGRARSE *(e.g. visitation, ayuda del reingreso)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de re-entry del preso?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

11. ENTRENAMIENTO/BUSQUEDA DE TRABAJO *(e.g. ayuda de resume)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios de asistencia trabajo de formación?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

12. SERVICIOS DE EMBARAZO/ CRIANZA DE LOS HIJOS *(e.g. educación y apoyo)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a sevicios del embarazos o criannza de los hijos?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

c. Marque las tres areas más necesitando adicional serivicios ☐

E. Data Sources for HEI Social Determinants

Social Determinants

- Civic Involvement
- Community Safety
- Economic Security
- Education
- Employment
- Environmental Quality
- Housing

Health Outcomes

- Accidents/Violence
- Cancer
- Cardiovascular Disease
- Childhood Illness
- Diabetes
- Health Care Access
- Infectious Disease
- Life Expectancy
- Liver Disease
- Mental Health
- Perinatal Care
- Renal Disease
- Respiratory Illness

For additional information about the HEI social determinants and health outcomes, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

F. Data Sources for Health Equity Index

Connecticut Secretary of State Office Voter Registration Statistics

Connecticut Department of Public Safety Uniform Crime Reports

2008 Warren Group Residential Statistics Report

2006-07 Home Mortgage Disclosure Act, Aggregate Reports; 2006-07 FFIEC Census Reports 2006-07

Housingpolicy.org

2000 US Census

Connecticut Department of Health Vital Records

RealtyTrac website, September 2008

2008 Connecticut Department of Social Services Temporary Family Assistance Data

Connecticut Department of Education's CEDaR site

2006 US Annual Economic Census ZIP Code Business Patterns reports; 2000 US Census

Connecticut Housing Finance Authority; 2005 US Census Population Survey

1995-2006 U.S. Annual Economic Survey

2002 US Economic Census Zip Code Statistics

US Environmental Protection Agency Toxic Release Inventory Program

Connecticut Housing Finance Authority; 2005 US Census Population Survey

Connecticut Department of Health, Office of Vital Records Death Certificates; 2007 Nielsen Claritas Population Facts Demographic Report

Connecticut Department of Health Tumor Registry; 2007 Nielsen Claritas Pop-Facts Demographic Report

2005 Connecticut Hospital Association CHIME Hospital Discharge Data

Connecticut Department of Health, Lead Poisoning Prevention and Control Program

Connecticut Department of Health, Office of Vital Records Birth Certificates

Connecticut Department of Health, Sexually Transmitted Surveillance Program

For additional information about the HEI data sources, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

Design by www.influentiald.com | Alberto Bonello

CITY OF HARTFORD DEPARTMENT OF HEALTH AND HUMAN SERVICES
131 Coventry Street | Hartford, CT 06112 | T 860.757.4700

EXHIBIT 22

KPMG

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Financial Statements and
Consolidating Information

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Health System, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Health System, Inc. (the System), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Health System, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

February 6, 2015

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 26,866	29,939
Short-term investments	17	29
Current portion of assets whose use is limited	5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,978 in 2014 and $9,395 in 2013	30,238	30,768
Other current assets	7,123	4,834
Total current assets	70,192	73,609
Marketable securities	24,966	22,365
Assets whose use is limited:		
By donor and held in trust by others	15,696	15,258
For estimated self-insurance liability	41,038	31,394
By bond indenture	4,321	4,324
Other	6	6
Total assets whose use is limited	61,061	50,982
Less current portion of assets whose use is limited	5,948	8,039
Noncurrent assets whose use is limited	55,113	42,943
Property and equipment, net	63,374	64,952
Other assets:		
Investments in joint venture arrangements	10,024	10,697
Deferred financing costs, net	103	128
Other noncurrent assets	241	241
Total other assets	10,368	11,066
Total assets	$ 224,013	214,935
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term obligations	$ 2,509	2,490
Accounts payable	17,369	20,985
Salaries, wages, and payroll withholdings	5,643	4,734
Due to third-party payors, net	783	6,035
Accrued expenses and other current liabilities	14,308	16,486
Total current liabilities	40,612	50,730
Long-term liabilities:		
Long-term obligations, net of current portion	17,891	20,374
Estimated self-insurance liability	31,814	21,908
Pension and deferred compensation	72,182	58,823
Other long-term liabilities	9,523	10,172
Total long-term liabilities	131,410	111,277
Net assets:		
Unrestricted	32,525	34,102
Noncontrolling interest in subsidiaries	370	302
Total unrestricted	32,895	34,404
Temporarily restricted	2,415	2,269
Permanently restricted	16,681	16,255
Total net assets	51,991	52,928
Total liabilities and net assets	$ 224,013	214,935

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowance	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	10,774	7,864
Total revenues	278,861	263,885
Expenses:		
Salaries and wages	113,553	108,933
Employee benefits	28,631	31,305
Supplies and other expenses	115,557	103,308
Provision for uncollectible accounts, net of recoveries	7	8
Depreciation and amortization	10,529	10,052
Interest	1,438	1,598
Total expenses	269,715	255,204
Operating income	9,146	8,681
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,684	1,758
Excess of revenues over expenses from continuing operations	12,830	10,439
Excess of revenue over expenses	12,830	10,439
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(387)	(485)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
Increase in unrestricted net assets	$ (1,509)	31,719

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,830	10,439
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(387)	(485)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,509)	31,719
Temporarily restricted net assets:		
Net assets released from restriction	(121)	(265)
Restricted contributions	267	165
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(937)	32,391
Net assets – beginning of year	52,928	20,537
Net assets – end of year	$ 51,991	52,928

See accompanying notes to consolidated financial statements.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (937)	32,391
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,529	10,052
Net loss on disposal of assets	46	230
Change in unrealized (gains) losses on investments	527	(401)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures and partnerships	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	530	3,317
Other current assets	(2,264)	5
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,671)	2,932
Estimated self-insurance liability	9,906	2,846
Pension, accrued compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,685	25,775
Cash flows from investing activities:		
Purchases of property and equipment	(7,211)	(16,884)
Distributions from joint ventures and partnerships	546	798
Investments in joint venture arrangements	316	(106)
Change in other assets whose use is limited	(6,258)	(2,284)
Change in assets held in trust by others	426	949
Net decrease in investments	(3,116)	(98)
Net cash used in investing activities	(15,297)	(17,625)
Cash flows from financing activities:		
Decrease (increase) in assets whose use is limited by bond indentures	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net increase (decrease) in cash and cash equivalents	(3,073)	6,250
Cash and cash equivalents – beginning of year	29,939	23,689
Cash and cash equivalents – end of year	$ 26,866	29,939
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,562
Assets acquired under capital lease	—	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Health System, Inc. (SMHS or the System) is a not-for-profit, nonstock Connecticut holding company. It is the sole member of Saint Mary's Hospital, Inc. (the Hospital) and Saint Mary's Hospital Foundation, Inc. (the Foundation).

The Hospital is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, Scovill, Partners, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The Foundation was organized to raise funds to support the Hospital.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone,

measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow us to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The System invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by the Hospital's wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess (deficiency) of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The System has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The System recorded $53,000 and $49,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which is included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the System which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and

gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments In Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the System has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the System, the accounts of the System are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the System.

(k) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the System's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses, and equity in earnings of joint ventures are considered in the performance measure.

(l) Income Taxes

The System, Hospital, and Foundation are tax-exempt organizations as described in Section 501(c)(3) of the Internal Revenue Code and are generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2014 or 2013.

(m) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(n) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(o) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(p) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services after allowance for the years ended September 30, 2014 and 2013, is as follows (in thousands):

	2014	2013
Gross revenue from patient services	$ 733,919	670,163
Contractual and other allowances	(454,430)	(401,170)
Charity care	(328)	(94)
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	$ 268,087	256,021

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

		Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$	271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$	257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 19,021	19,021	—	—	—	—
Corporate bonds	12,451	12,428	1,088	(19)	4,653	(163)
U.S. government and agency obligations	14,177	14,141	2,926	(16)	1,686	(34)
Mutual funds	28,344	23,521	605	(62)	—	—
Equities	1,145	1,173	608	(9)	—	—
	$ 75,138	70,284	5,227	(106)	6,339	(197)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,809	2,809	—	—	—	—
Corporate bonds	15,837	16,628	928	(54)	734	(53)
U.S. government and agency obligations	13,930	13,135	3,731	(42)	304	(5)
Mutual funds	29,961	23,519	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 67,170	60,143	5,365	(112)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 18,229	—	—	18,229
Domestic corporate bonds	—	10,469	—	10,469
U.S. government and agency obligations	—	12,501	—	12,501
Equity mutual funds	17,635	—	—	17,635
Fixed income mutual funds	277	—	—	277
Equity funds	331	—	—	331
Total	36,472	22,970	—	59,442
Assets held in trust by others: Perpetual trust	—	—	15,696	15,696
Total	$ 36,472	22,970	15,696	75,138

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,445	—	—	2,445
Domestic corporate bonds	—	13,477	—	13,477
U.S. government and agency obligations	—	11,679	—	11,679
Equity mutual funds	19,508	—	—	19,508
Fixed income mutual funds	315	—	—	315
Equity funds	4,488	—	—	4,488
Total	26,756	25,156	—	51,912
Assets held in trust by others: Perpetual trust	—	—	15,258	15,258
Total	$ 26,756	25,156	15,258	67,170

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the System's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

Perpetual Trust	2014	2013
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains and losses	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(Continued)

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,926	7,343
Buildings and building improvements (10–40 yrs)	69,714	69,638
Equipment (3–25 yrs)	122,712	114,008
Projects in process	394	1,357
	200,746	192,346
Less accumulated depreciation and amortization	(137,372)	(127,394)
Property and equipment, net	$ 63,374	64,952

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997, the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund for the Bonds issued through CHEFA, of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds issued through CHEFA, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,310 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 34,404	34,102	302
Excess of revenues over expenses	12,830	12,398	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(387)	(23)	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 32,895	32,525	370

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 2,685	2,333	352
Excess of revenues over expenses	10,439	10,084	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(485)	(80)	(405)
Change in unrealized gains (losses) on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 34,404	34,102	302

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The System's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the System has no funds designated by the Board of Directors as endowment.

The System has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The System classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the System in a manner consistent with the standard of prudence prescribed by the Act.

The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the System and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$ 457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$ 375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$ 375	16,255	16,630
Investment return:			
Investment income	110	913	1,023
Net appreciation (depreciation)	(23)	264	241
Total investment return	87	1,177	1,264
Appropriation of endowment assets for expenditure	(5)	(751)	(756)
Endowment net assets, September 30, 2014	$ 457	16,681	17,138

(Continued)

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	375	16,255	16,630

The System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the System's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The System targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The System follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the System expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability claims have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and subject to change. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premium held on deposit at end of year	$	15,115	10,544

(Continued)

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The net actuarial loss that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit costs and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

(Continued)

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

(Continued)

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2022		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,147,000 and $5,982,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried on the equity basis, and the carrying value is

approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 671	543
Net assets released from restriction	46	68
Contributions	561	658
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful Use	2,962	1,149
Other	1,971	1,009
Total	$ 10,774	7,864

(19) Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,785	39,406
Fundraising	693	591
	$ 269,715	255,204

(20) Subsequent Events

The System has evaluated events through February 6, 2015, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the System's consolidated financial statements except as disclosed below.

The Hospital entered into an agreement to purchase 30.3% interest from limited partners of Naugatuck Valley MRI Limited Partnership for $700,000 in December 2014. The entity will be consolidated as a subsidiary in the consolidated financial statements going forward.

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Current assets:					
Cash and cash equivalents	$ 25,797	1,069	—	—	26,866
Short-term investments	17	—	—	—	17
Current portion of assets whose use is limited	5,948	—	—	—	5,948
Accounts receivable, net	30,196	42	—	—	30,238
Other current assets	6,612	15	520	(24)	7,123
Total current assets	68,570	1,126	520	(24)	70,192
Marketable securities	20,803	4,163	—	—	24,966
Assets whose use is limited:					
By donor and held in trust by others	15,696	—	—	—	15,696
For estimated self-insurance liability	41,038	—	—	—	41,038
By bond indenture	4,321	—	—	—	4,321
Net interest in Foundation	5,182	—	—	(5,182)	—
Other	6	—	—	—	6
Total assets whose use is limited	66,243	—	—	(5,182)	61,061
Less current portion of assets whose use is limited	5,948	—	—	—	5,948
Noncurrent assets whose use is limited	60,295	—	—	(5,182)	55,113
Property and equipment, net	62,371	4	999	—	63,374
Other assets:					
Investments in joint venture arrangements	10,024	—	—	—	10,024
Deferred financing costs, net	103	—	—	—	103
Other noncurrent assets	—	—	241	—	241
Total other assets	10,127	—	241	—	10,368
Total assets	$ 222,166	5,293	1,760	(5,206)	224,013

(Continued)

Exhibit 1

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation, Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Current liabilities:					
Current portion of long-term obligations	$ 2,509	—	—	—	2,509
Accounts payable	17,252	87	30	—	17,369
Salaries, wages, and payroll withholdings	5,643	—	—	—	5,643
Due to third-party payors, net	783	—	—	—	783
Accrued expenses and other current liabilities	14,308	24	—	(24)	14,308
Total current liabilities	40,495	111	30	(24)	40,612
Long-term liabilities:					
Long-term obligations, net of current portion	17,891	—	—	—	17,891
Estimated self-insurance liability	31,814	—	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	72,182
Other long-term liabilities	9,523	—	—	—	9,523
Total long-term liabilities	131,410	—	—	—	131,410
Net assets (deficit):					
Unrestricted	30,795	1,923	1,730	(1,923)	32,525
Noncontrolling interest in subsidiaries	370	—	—	—	370
Total unrestricted	31,165	1,923	1,730	(1,923)	32,895
Temporarily restricted	2,415	2,291	—	(2,291)	2,415
Permanently restricted	16,681	968	—	(968)	16,681
Total net assets	50,261	5,182	1,730	(5,182)	51,991
Total liabilities and net assets	$ 222,166	5,293	1,760	(5,206)	224,013

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HEALTH SYSTEM, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital, Inc. Consolidated	Saint Mary's Hospital Foundation, Inc.	Saint Mary's Health System Inc.	Eliminations	Saint Mary's Health System, Inc. Consolidated
Revenues:					
Revenue from patient services, net of contractual allowance	$ 279,161	—	—	—	279,161
Provision for uncollectible accounts, net of recoveries	(11,074)	—	—	—	(11,074)
Net revenue from patient services	268,087	—	—	—	268,087
Other operating revenues	9,776	998	156	(156)	10,774
Total revenues	277,863	998	156	(156)	278,861
Expenses:					
Salaries and wages	113,207	308	38	—	113,553
Employee benefits	28,620	—	11	—	28,631
Supplies and other expenses	115,262	377	74	(156)	115,557
Provision for uncollectible accounts	—	7	—	—	7
Depreciation and amortization	10,455	1	73	—	10,529
Interest	1,438	—	—	—	1,438
Total expenses	268,982	693	196	(156)	269,715
Operating income (loss)	8,881	305	(40)	—	9,146
Nonoperating gains (losses):					
Investment income, net	3,824	—	—	—	3,824
Equity in earnings of joint ventures	189	—	—	—	189
Change in net assets of Foundation	281	—	—	(281)	—
Net loss on disposal of assets	(46)	—	—	—	(46)
Other	(283)	—	—	—	(283)
Total nonoperating gains, net	3,965	—	—	(281)	3,684
Excess (deficiency) of revenues over (under) expenses	12,846	305	(40)	(281)	12,830
Net assets released from restriction for capital expenditures	(48)	(5)	—	5	(48)
Capital transactions with affiliates	(363)	—	—	(24)	(387)
Change in unrealized gains on marketable securities and other assets whose use is limited	(527)	(138)	—	138	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	(13,377)
Increase (decrease) in unrestricted net assets	(1,469)	162	(40)	(162)	(1,509)

See accompanying independent auditors' report.

KPMG

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

December 22, 2014

SAINT MARY'S HOSPITAL, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 25,797	28,902
Short-term investments	17	29
Current portion of assets whose use is limited	5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013	30,196	30,730
Other current assets	6,612	4,357
Total current assets	68,570	72,057
Marketable securities	20,803	18,506
Assets whose use is limited:		
By donor and held in trust by others	15,696	15,258
For estimated self-insurance liability	41,038	31,394
By bond indenture	4,321	4,324
Net interest in Foundation	5,182	4,874
Other	6	6
Total assets whose use is limited	66,243	55,856
Less current portion of assets whose use is limited	5,948	8,039
Noncurrent assets whose use is limited	60,295	47,817
Property and equipment, net	62,371	63,874
Other assets:		
Investments in joint venture arrangements	10,024	10,697
Deferred financing costs, net	103	128
Total other assets	10,127	10,825
Total assets	$ 222,166	213,079
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term obligations	$ 2,509	2,490
Accounts payable	17,252	20,899
Salaries, wages, and payroll withholdings	5,643	4,734
Due to third-party payors, net	783	6,035
Accrued expenses and other current liabilities	14,308	16,486
Total current liabilities	40,495	50,644
Long-term liabilities:		
Long-term obligations, net of current portion	17,891	20,374
Estimated self-insurance liability	31,814	21,908
Pension and deferred compensation	72,182	58,823
Other long-term liabilities	9,523	10,172
Total long-term liabilities	131,410	111,277
Net assets:		
Unrestricted Hospital	30,795	32,332
Noncontrolling interest in subsidiaries	370	302
Total unrestricted	31,165	32,634
Temporarily restricted	2,415	2,269
Permanently restricted	16,681	16,255
Total net assets	50,261	51,158
Total liabilities and net assets	$ 222,166	213,079

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowances	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	9,776	6,871
Total revenues	277,863	262,892
Expenses:		
Salaries and wages	113,207	108,642
Employee benefits	28,620	31,294
Supplies and other expenses	115,262	103,072
Depreciation and amortization	10,455	9,977
Interest	1,438	1,594
Total expenses	268,982	254,579
Operating income	8,881	8,313
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Change in net assets of Foundation	281	437
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,965	2,195
Excess revenues over expenses	12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	$ (1,469)	31,754

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,469)	31,754
Temporarily restricted net assets:		
Change in net assets of Foundation	146	(100)
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(897)	32,426
Net assets – beginning of year	51,158	18,732
Net assets – end of year	$ 50,261	51,158

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (897)	32,426
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,480	10,003
Net loss on disposal of assets	46	230
Change in unrealized losses (gains) on investments	527	(401)
Change in net interest in Foundation	(308)	(379)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	534	3,287
Other current assets	(2,255)	125
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,702)	1,522
Estimated self-insurance liability	9,906	2,846
Pension, deferred compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,350	24,062
Cash flows from investing activities:		
Purchases of property and equipment	(7,212)	(15,479)
Distributions from joint ventures	546	420
Investments in joint venture arrangements	316	272
Change in other assets whose use is limited	(6,258)	106
Change in assets held in trust by others	426	949
Net decrease in investments	(2,812)	(2,052)
Net cash used in investing activities	(14,994)	(15,784)
Cash flows from financing activities:		
Change in assets whose use is limited by bond indenture	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net (decrease) increase in cash and cash equivalents	(3,105)	6,378
Cash and cash equivalents – beginning of year	28,902	22,524
Cash and cash equivalents – end of year	$ 25,797	28,902
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,558
Supplemental disclosure of noncash item:		
Assets acquired under capital lease	$ —	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments in Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Interest in Foundation

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

(k) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

(l) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

(m) Income Taxes

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

(n) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(o) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(p) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(q) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

		2014	2013
Gross revenue from patient services	$	733,919	670,163
Contractual and other allowances		(454,430)	(401,170)
Charity care		(328)	(94)
Provision for uncollectible accounts, net of recoveries		(11,074)	(12,878)
Net revenue from patient services	$	268,087	256,021

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$ 271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$ 257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 18,630	18,630	—	—	—	—
Corporate bonds	11,820	11,807	1,062	(18)	4,559	(162)
U.S. government and agency obligations	14,023	13,990	2,926	(16)	1,686	(34)
Mutual funds	25,357	21,016	608	(9)	—	—
Equities	1,145	1,173	605	(62)	—	—
	$ 70,975	66,616	5,201	(105)	6,245	(196)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,671	2,671	—	—	—	—
Corporate bonds	15,083	15,885	4,668	(274)	734	(53)
U.S. government and agency obligations	13,769	12,984	3,731	(42)	304	(5)
Mutual funds	27,155	21,326	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 63,311	56,918	9,105	(332)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 17,838	—	—	17,838
Domestic corporate bonds	—	9,838	—	9,838
U.S. government and agency obligations	—	12,347	—	12,347
Equity mutual funds	14,925	—	—	14,925
Equity funds	331	—	—	331
Total	33,094	22,185	—	55,279
Assets held in trust by others:				
Perpetual trust	—	—	15,696	15,696
Total	$ 33,094	22,185	15,696	70,975

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,307		—	2,307
Domestic corporate bonds	—	12,723	—	12,723
U.S. government and agency obligations	—	11,518	—	11,518
Equity mutual funds	17,017	—	—	17,017
Equity funds	4,488	—	—	4,488
Total	23,812	24,241	—	48,053
Assets held in trust by others:				
Perpetual trust	—	—	15,258	15,258
Total	$ 23,812	24,241	15,258	63,311

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

	2014	2013
Perpetual trust:		
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,911	7,328
Buildings and building improvements (10–40 yrs)	67,094	67,017
Equipment (3–25 yrs)	122,662	114,099
Projects in process	395	1,217
	198,062	189,661
Less accumulated depreciation and amortization	(135,691)	(125,787)
Property and equipment, net	$ 62,371	63,874

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 32,634	32,332	302
Excess (deficiency) of revenues over expenses	12,846	12,414	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(363)	1	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 31,165	30,795	370

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 880	528	352
Excess (deficiency) of revenues over expenses	10,508	10,153	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(519)	(114)	(405)
Change in unrealized gains on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 32,634	32,332	302

(Continued)

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by the Act.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$ 457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$ 375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$ 375	16,255	16,630
Investment return:			
Investment income	110	913	1,023
Net (depreciation) appreciation	(23)	264	241
Total investment return	87	1,177	1,264
Appropriation of endowment assets for expenditure	(5)	(751)	(756)
Endowment net assets, September 30, 2014	$ 457	16,681	17,138

(Continued)

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	$ 261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	$ 375	16,255	16,630

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premiums held on deposit at end of year	$	15,115	10,544

(Continued)

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Preferred equity securities	—	—	—	—
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

(Continued)

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2024		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 280	276
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful use	2,962	1,149
Other	1,971	1,009
Total	$ 9,776	6,871

(19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,745	39,372
	$ 268,982	254,579

(20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

(21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current assets:						
Cash and cash equivalents	$ 24,610	823	—	364	—	25,797
Short-term investments	17	—	—	—	—	17
Current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Accounts receivable, net	26,816	2,999	(68)	381	68	30,196
Other current assets	6,108	253	5,749	17	(5,515)	6,612
Total current assets	58,696	4,075	10,484	762	(5,447)	68,570
Marketable securities	20,803	—	—	—	—	20,803
Assets whose use is limited:						
By donor and held in trust by others	15,696	—	—	—	—	15,696
For estimated self-insurance liability	—	—	41,038	—	—	41,038
By bond indenture	4,321	—	—	—	—	4,321
Net interest in Foundation	5,182	—	—	—	—	5,182
Other	6	—	—	—	—	6
Total assets whose use is limited	25,205	—	41,038	—	—	66,243
Less current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Noncurrent assets whose use is limited	24,060	—	36,235	—	—	60,295
Property and equipment, net	59,768	1,417	—	1,186	—	62,371
Other assets:						
Investments in joint venture arrangements	23,723	—	—	—	(13,699)	10,024
Deferred financing costs, net	103	—	—	—	—	103
Total other assets	23,826	—	—	—	(13,699)	10,127
Total assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

(Continued)

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current liabilities:						
Current portion of long-term obligations	$ 2,101	—	—	408	—	2,509
Accounts payable	16,795	432	—	25	—	17,252
Salaries, wages, and payroll withholdings	3,974	1,370	—	299	—	5,643
Due to third-party payors, net	783	—	—	—	—	783
Accrued expenses and other current liabilities	13,994	504	5,038	219	(5,447)	14,308
Total current liabilities	37,647	2,306	5,038	951	(5,447)	40,495
Long-term liabilities:						
Long-term obligations, net of current portion	17,818	—	—	73	—	17,891
Estimated self-insurance liability	3,278	—	28,536	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	—	72,182
Other long-term liabilities	9,464	59	—	—	—	9,523
Total long-term liabilities	102,742	59	28,536	73	—	131,410
Net assets (deficit):						
Unrestricted	27,668	3,127	13,145	924	(14,069)	30,795
Noncontrolling interest in subsidiaries	—	—	—	—	370	370
Total unrestricted	27,668	3,127	13,145	924	(13,699)	31,165
Temporarily restricted	2,415	—	—	—	—	2,415
Permanently restricted	16,681	—	—	—	—	16,681
Total net assets	46,764	3,127	13,145	924	(13,699)	50,261
Total liabilities and net assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HOSPITAL, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Revenues:						
Revenue from patient services, net of contractual allowances	$ 248,807	24,157	—	6,197	—	279,161
Provision for uncollectible accounts	(10,078)	(996)	—	—	—	(11,074)
Net revenue from patient services	238,729	23,161	—	6,197	—	268,087
Other operating revenues	8,706	4,039	5,070	16	(8,055)	9,776
Total revenues	247,435	27,200	5,070	6,213	(8,055)	277,863
Expenses:						
Salaries and wages	85,350	26,689	—	1,168	—	113,207
Employee benefits	24,562	3,778	—	280	—	28,620
Supplies and other expenses	106,022	9,260	4,092	3,370	(7,482)	115,262
Depreciation and amortization	9,888	283	—	284	—	10,455
Interest	1,405	—	—	33	—	1,438
Total expenses	227,227	40,010	4,092	5,135	(7,482)	268,982
Operating income (loss)	20,208	(12,810)	978	1,078	(573)	8,881
Nonoperating gains (losses):						
Investment income, net	2,279	—	1,545	—	—	3,824
Equity in earnings of joint ventures	3,359	—	—	—	(3,170)	189
Change in net assets of Foundation	281	—	—	—	—	281
Net loss on disposal of assets	(46)	—	—	—	—	(46)
Other	(856)	—	—	—	573	(283)
Total nonoperating gains (losses), net	5,017	—	1,545	—	(2,597)	3,965
Excess (deficiency) of revenues over expenses	25,225	(12,810)	2,523	1,078	(3,170)	12,846
Net assets released from restriction	(48)	—	—	—	—	(48)
Capital transactions, net	(14,778)	14,778	—	(910)	547	(363)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	—	(486)	—	486	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	—	(13,377)
(Decrease) increase in unrestricted net assets	$ (3,505)	1,968	2,037	168	(2,137)	(1,469)

See accompanying independent auditors' report.

EXHIBIT 23

Internal Revenue Service

Date: JAN 15 2009

SAINT MARYS HOSPITAL INC
56 FRANKLIN ST
WATERBURY CT 06706-1253

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:
Michelle Jones
ID# 0203153
Toll Free Telephone Number:
877-829-5500
Federal Identification Number:
06-0646844
Group Exemption Number:
0928

Dear Sir or Madam:

This is in response to your request of November 14, 2008, regarding your tax-exempt status.

Our records indicate that you are recognized as exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. You are included in the group ruling issued to the United States Conference of Catholic Bishops, which is not a private foundation within the meaning of 509(a) of the Code because it is described in section 509(a)(1) and 170(b)(1)(A)(i).

The United States Conference of Catholic Bishops is listed in Publication 78. Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to them or for their use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Since you are included in a group ruling, there is no individual exemption letter. The group exemption letter applies to all of the subordinate organizations on whose behalf the United States Conference of Catholic Bishops has applied for recognition of exemption. If you want a copy of the group exemption letter, please contact your central organization.

If you are operating an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, you are required to file Form 5578, *Annual Certification of Racial Nondiscrimination for a Private School Exempt From Federal Income Tax.* Form 5578 is due annually by the 15th day of the 5th month following the end of the organization's accounting period.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

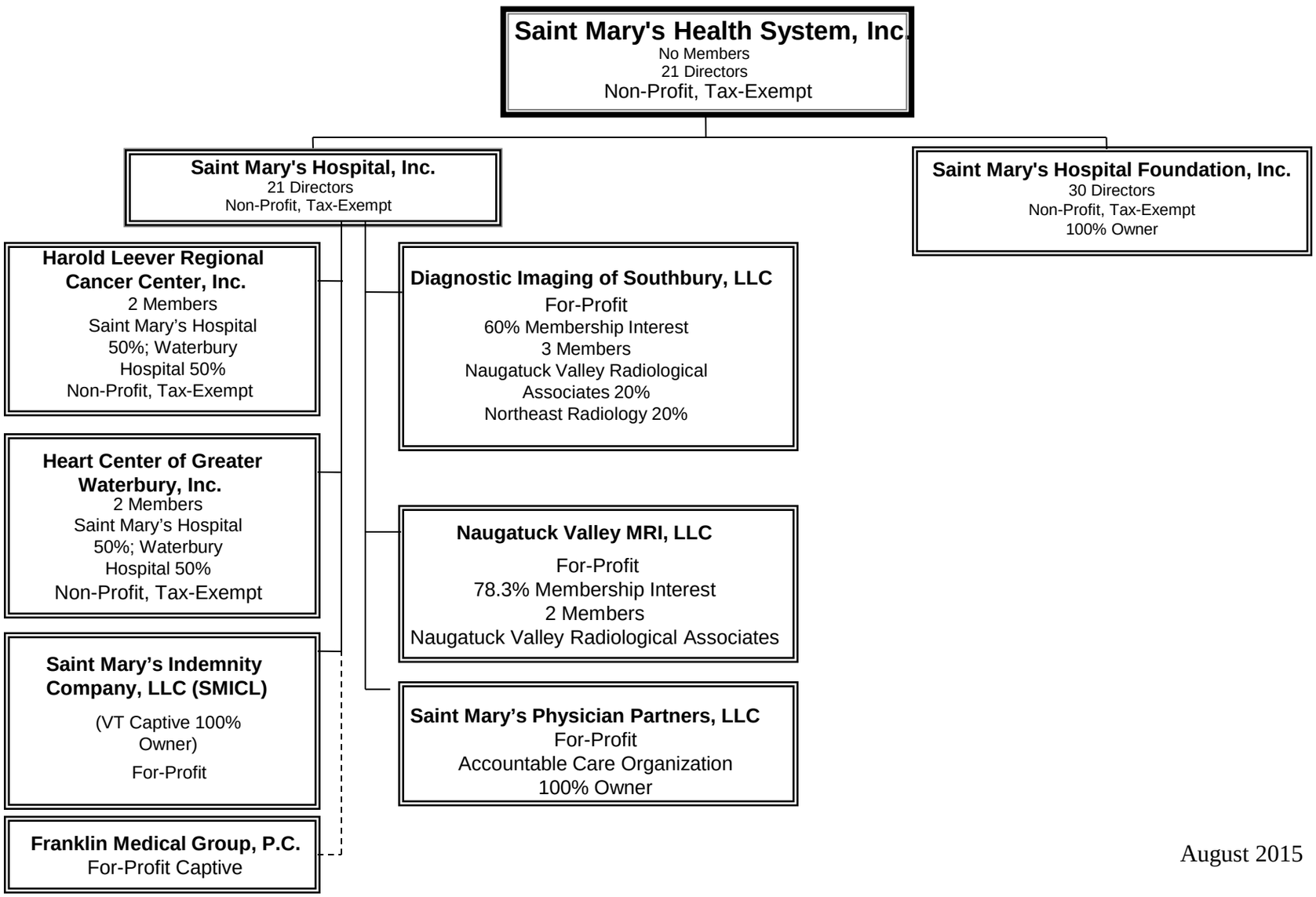
Sincerely,

Cindy Westcott

Cindy Westcott,
Manager, Exempt Organizations
Determinations

EXHIBIT S1

Corporate Structure



August 2015

EXHIBIT S2

Saint Mary's Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 1,800 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2013, Saint Mary's Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with The Greater Waterbury Health Improvement Partnership. The partnership consists of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Saint Mary's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs.

THE CHNA PROCESS

Saint Mary's Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Community Needs
6. Implementation Strategy

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Waterbury Department of Public Health, Connecticut Department of Health, and Centers for Disease Control and Prevention, among others. The report depicts the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System (BRFSS) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Saint Mary's Hospital in addressing the identified barriers.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA) and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

Saint Mary's Hospital developed an **Implementation Strategy** to outline what community health needs it plans to address, as well as specific goals and measures to evaluate community health improvement initiatives.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated by partners of the the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives of the session were:

- To review recently compiled community health data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

Prioritization Process

Holleran Consulting facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community. Through facilitated discussion, attendees developed the following "Master List" of potential priority areas.

Master list of community priorities (in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

Key Community Health Issues

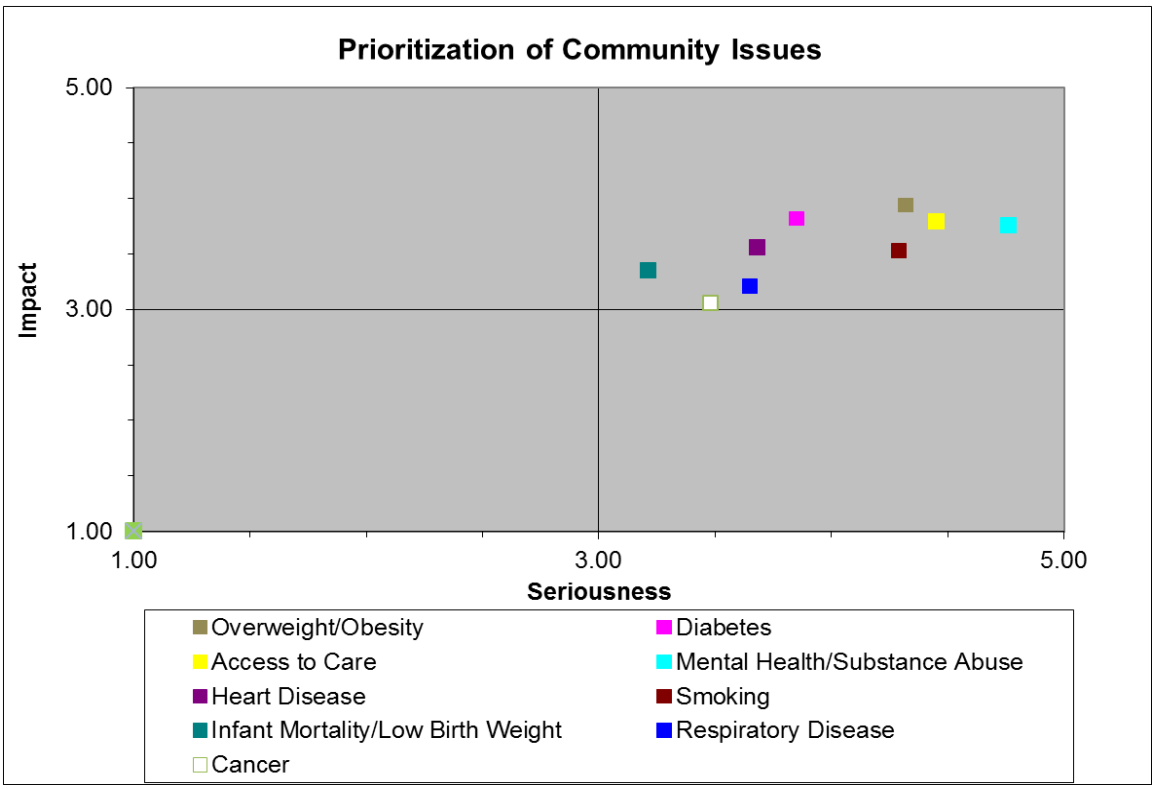
Once the Master List was compiled, participants were asked to rate each need based on two criteria. The two criteria included the "seriousness of the issue" and the "community's ability to impact the issue." Respondents were asked to rate each issue on a scale of 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact). The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee

received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.76), followed by Access to Care (4.45), and Overweight and Obesity (4.32). The ability to impact Overweight and Obesity was rated the highest (3.94), followed by Diabetes (3.82), and Access to Care (3.79).

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Chronic Disease (Obesity, Diabetes, Heart Disease and Asthma)
- Smoking

STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the four priority areas are listed below.

I. Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

Key Indicators:

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

Existing Programs

Hospital-Based Access to Care Programs

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2012, these advocates assisted 656 individuals in obtaining insurance coverage.

Grant-Funded

- Saint Mary's has received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs Medical Home. This Medical Home develops care plans and provides healthcare for children and youth with chronic physical and/or behavioral issues.
- Saint Mary's has grant funding from the Connecticut Department of Public Health for the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS), which was formerly known as the Breast and Cervical Grant. This program provides screening for breast and cervical cancer and if a cancer is diagnosed through the grant, funds are available for treatment. CHDIHS recently integrated a colorectal screening component.
- Saint Mary's Children's and Family Health Center, Dental Clinic and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have

Medicaid. Thousands of patients receive services through these clinics; these clinics have over 50,000 visits per year.

Initiatives

- Collaborate with the Connecticut Health Insurance Exchange to help residents gain access to health insurance.
- Evaluate opportunities to improve access to primary and urgent care.
- Enhance cost estimate and insurance verification programs so patients can better understand financial responsibilities in advance.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care) for uninsured/underinsured and low income patients and families.
- Develop nurse navigator programs where appropriate to improve access to primary care and behavioral health.

Existing Community Resources

Chase Family Resource Center
Community Health Centers, Inc.
Malta House of Care
New Opportunities, Inc.
StayWell Health Center, Inc.
Waterbury Health Access Program
Waterbury Department of Public Health

II. Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase number of points of access for referral to services

Key Indicators

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental / behavioral health.
- Length of stay in ED for mental / behavioral health patients.
- Number of ED referrals for mental / behavioral health care services.

Existing Programs

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 12, 611 patients were discharged from the unit. The average length of stay in the unit is 6.36 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,800 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2012, 11,163 ED patients had a primary diagnosis related to behavioral health. These patients represent 16% of total visits (70,067). The average length of stay for behavioral health patients in the ED was 38.4 hours or 1.6 days. Some of the ED behavioral health patients receive services in the seven-bed behavioral health holding unit.

Initiatives

- Evaluate options to enhance Behavioral Health unit in the Emergency Department to better meet patient needs.
- Analyze potential for development of a Community Crisis Center or Behavioral Health Walk In Center.
- Evaluate options to develop a Geriatric Emergency Department Program to reduce unnecessary ED utilization.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions.
- Evaluate Community Care Team program based at Middlesex Hospital and determine if a similar model could work in Waterbury.
- Evaluate potential for an ambulatory detoxification program.

Resources

Catholic Family Services
Community Health Centers, Inc.
Family Services of Greater Waterbury
Home to Home Foundation
Neighborhood Housing Services of Waterbury
StayWell Health Center, Inc.
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Youth Services
Wellmore Behavioral Health

III. Chronic Diseases (Obesity, Heart Disease, Diabetes, and Asthma)

Goal: Promote health and reduce chronic disease through healthy eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Reduce risk factors for chronic disease

Indicators:

- Number and percent of patients who are obese or overweight at the time of their visit.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children in the Early Obesity Prevention Program that demonstrate improved weight.
- Number of children who receive meals through the Health Nutrition Grant.
- Number of physicians participating in the Easy Breathing Program.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Number and percent of residents utilizing the farmer's market who report increased consumption of fruits and vegetables.
- Number of food prescriptions written.

Existing Programs

Obesity and Heart Disease

- Saint Mary's offers inpatient and outpatient nutritional counseling.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2012, 112 patients had obesity surgery.
- Saint Mary's works with community organizations on the Early Childhood Obesity Prevention Program. This program is funded by Saint Mary's Hospital, the Connecticut Community Foundation and the American Heart Association. The grant is in its first phase to collect local data on childhood obesity. The second phase will include developing interventions to reduce obesity.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a Mindful Meal Program that includes low calorie and low fat healthy food options.

Asthma and Diabetes

- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- The Connecticut Community Foundation and the American Hospital Association has awarded Saint Mary's a grant for diabetes education in the Naugatuck area. This is collaboration with the Heart Center of Greater Waterbury.

Initiatives

- Collaborate with Brass City Harvest to offer a farmer's market.
- Evaluate ways to continue to improve meal choices at the hospital.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Participate in the American Heart Association Mission Lifeline Program.
- Determine possibility of holding community education and screening events in collaboration with local providers.
- Provide nurse educator to patients with Congestive Heart Failure to coordinate post-acute care services and provide patient and family education.

Resources

- Brass City Harvest
- Bridge to Success Community Partnership
- Community Health Centers, Inc.
- End Hunger Connecticut
- Heart Center of Greater Waterbury
- New Opportunities, Inc.
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

IV. Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Key Indicators

- Number of people participating in smoking cessation programs and percent that successfully quit smoking.
- Number of patients who receive smoking cessation counseling.

Existing Programs

- The American Lung Association has awarded Saint Mary's tobacco cessation funds. Funds are currently available to cessation classes.
- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.

Initiatives

- Work with Harold Leever Regional Cancer Center to enhance smoking cessation program.
- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.

Resources

- Community Health Centers, Inc.
- Harold Leever Regional Cancer Center
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Saint Mary's Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Saint Mary's Hospital Board of Directors met on September 12, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants – June 18, 2013

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living

Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT S3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/14

NAME OF FACILITY SAINT MARY'S HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 56 FRANKLIN ST, WATERBURY, CT 06706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A000	INITIAL COMMENTS An authorized substantial allegation survey was concluded on October 29, 2014 in response to complaint #CT 17479 at: Saint Mary's Hospital 56 Franklin St. Waterbury, CT 06706 The following Conditions of Participation were reviewed as they pertain to the complaint: Physical Environment 482.41 Infection Control 482.42 Governing Body 482.12 QAPI 482.21 Pharmaceutical Services 482.25	A000		
A083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions for the contracted service.	A083		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) Date

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A083	This STANDARD is not met as evidenced by: Based on observation, a review of facility documentation, and staff interviews the facilities governing body failed to ensure the hospitals quality program assessed services provided by an outside environmental monitoring company to identify quality and performance issues. The finding includes: During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the	A083	Applies to tag A083 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board. Responsible Person: Director of Pharmacy	October 30, 2014 Indefinite

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A083	Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. Interview with the Vice President of Nursing on 10/29/14 at 1:30 PM identified the governing body was not made aware of the environmental testing that was conducted in the pharmacy to ensure monitoring, improvement activities, and sustainability of quality problems. The hospital bylaws dated 12/20/07 directed in part, the quality coordinating council would monitor the performance improvement activities carried out within the hospital. Further review of the bylaws identified the governing body would be responsible to review infection control as it is related to the development of a mechanism for monitoring and reporting environmental condition with infection potential.	A083		
A273	482.21(a), (b)(1), (b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve	A273		

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A273	Health outcomes (2) The hospital must measure, analyze, and track quality indicators and other aspects of performance that assess processes of care, hospital services and operations. (b) Program data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care and (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidence by: Based on a review of the hospital documentation and interview with hospital personnel, the facility failed to assess and/or analyze environmental testing conducted in the pharmacy and/or failed to incorporate the hospital's quality improvement program to ensure patient safety and quality of care. The finding includes: .	A273		

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A273	During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. The hospital's performance improvement management plan directed in part, a performance improvement plan specific to the department's scope of care and to ensure the deployment of strategies based on measurement and assessment of process and outcomes.	A273	Applies to tag A273 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board. Responsible Person: Director of Pharmacy	

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	The chief executive officer, senior leadership and the executive leadership team would be responsible for assuring the identified key projects are reflected, measured and evaluated in the performance improvement plan with outcomes documented.			
A724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on review of facility documentation, review of facility policy, review of manufacturer's recommendations, observations and interviews, the facility failed to ensure that pharmacy equipment inspections and/or cleaning maintenance was conducted/documented as per manufacturer's recommendation, and/or facility policy and/or state law. The finding includes: A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00 PM identified that the pharmacy had three glove compounding isolators. Isolator #3 had a maintenance sticker dated fir 9/2014 on the outer right side of the isolator. Review of isolator inspection documentation on 108/28/14 at 2:05PM indicated that all three isolators had HEPA	A724	Applies to tag A724 Pharmacy Department and Facilities have both created an automated alert 3 weeks prior to the required inspection of the isolators as a reminder for follow up to Facilities contracted service for cleaning. In addition to contracted cleaning, twice monthly terminal cleaning has been scheduled with sporacidal disinfectant for the IV rooms. Monitoring: Pharmacy Department will maintain an inspection log and this will be submitted to the Quality Department on an annual basis. Responsible Person: Director of Pharmacy	

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A724	Filters and air velocity testing, by Company #2 on 1/20/13 and 7/8/13, testing was not conducted for January 2014. A change in vendor on 9/24/14 identified that Company #3 only tested isolators #2 and #3, and that isolator #1 was not tested. Interview with the Director of Pharmacy on 10/28/14 at 2:05 PM noted that there was a glitch in the testing schedule, Company #2 did not test the equipment in January 2014 as per contract and Company #3 was only capable of testing the positive pressure isolators, Isolator #2 and #3. The facility submitted a corrective action plan on 10/28/14 that included testing of the negative pressure isolator, Isolator 31, scheduled for 10/29/14. The facility IV Infection Control policy directed that, barrier isolators are inspected and certified every six months.	A724	Applies to tag A749 Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings. Monitoring: Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board.	
A749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying documentation, review of facility policy, and interviews the facility failed to ensure that the infection control department was informed of positive mold cultures in the medication compounding area. The finding includes: 1. A tour of the pharmacy department was conducted on 10/27/14 at 2:00PM with the Director of Pharmacy. Observation on 10/27/14 at 2:00PM identified a door at the back of the department lead to a room that contained, in part, three isolators for medication compounding. Review of facility	A749	Responsible Person: Director of Pharmacy	October 30, 2014 Indefinite

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A749	contracts and/or environmental monitoring reports on 10/27/14 indicated that Company #1 performed environmental culturing in the pharmacy department as per facility contract. The monitoring reports further noted that 1 to 3 mold spores were cultured on the surfaces and/or floor and/or in the air of the medication compounding room (not in the compounding isolators) in January, February, May, June, July, August, and September 2014. The monitoring reports further documented that the Director of Pharmacy did not take steps to remediate the presence of mold until June 2014 when cleaning processes were reviewed, and/or when dynamic testing was conducted in August 2014 and/or the institution of a "sticky mat" in September 2014. Review of Pharmacy and Therapeutics committee minutes from 1/2014 to 9/2014 lacked documentation of the mold spores and/or the steps taken by pharmacy to remediate the mold. Review of Infection Control (IC) meeting minutes from 1/2014 to 9/2014 lacked documentation of the pharmacy cultures and/or remediation. Interview with the Director of Pharmacy on 10/27/14 at 2:30PM identified that although the pharmacy mold levels were far below actionable levels, he consulted with the contracted microbiologist for ideas to eliminate/decrease the mold.	A749		

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A749	Review of IC meeting minutes and further interview with the Director of Pharmacy on 10/27/14noted that the IC team had never been made aware of an/or been involved in environmental culturing results/remediation's as the levels were non-actionable. Interview with the Infectious Disease Physician on 10/29/14 at 11:12Am indicated that, going forward, he/she would like to see a grid to reflect known unacceptable culture levels and the pharmacy culture results trends. The facility IC plan identified that the program was an institution-wide program whose main objectives are the prevention and control of infections. The IC plan included a major function to design and execute routine surveillance data collection and analysis activities and to develop review, and revise hospital-wide infection prevention policies and procedures. According to the USP 797, highly pathogenic microorganisms, to include mold, must be immediately remedied regardless of the colonizing forming unit count, with the assistance of a competent microbiologist, IC professional or industrial hygienist. 2. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items in the antechamber of Isolator #3, sprayed the antechamber with sterile 70% Isopropyl alcohol and after donning	A749		

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A749	the isolator's gloves/sleeves, moved the items form antechamber to the main chamber and began the medication compounding procedure. Following the procedure, Pharmacy Technician #1 moved the items to the antechamber, removed his/her gloved hands from the isolator's gloves/sleeves and removed all items from the antechamber. Pharmacy cleaning logs identified that Glove Box A and Glove Box B (Isolators #2 and #3) were cleaned on each shift. The cleaning logs laced evidence of any additional cleaning of Isolators #1 and/or cleaning of the negative pressure isolator (Isolator #1). In addition documentation could not be provided for required isolator glove changes. Interview with the Director of Pharmacy on 10/27/14 at 2:30 PM indicated that isolator glove are changed daily and on the morning shift and that this was not documented. He further noted that additional cleaning of isolators was performed if soiling was noted in the chamber and was not performed between compounding – sterile preparations (CSP). Interview with the Performance Improvement Specialist on 10/28/14 at 8:55AM noted that the pharmacist would change gloves in Isolator #1 each day the isolator was used, which was approximately once a week and that this was not documented. Manufacturer's recommendations for the IV isolators directed cleaning and disinfecting the isolator at the beginning of each shift and cleaning and sanitizing the isolator between CSP.	A749	Applies to tag A749 The isolator daily logs have been updated to include isolation unit #1 and the frequency of changing of the isolator gloves. The IV room IC policy was revised to change isolator glove changes from every other day to daily. Monitoring: The isolator logs will be audited weekly for 6 weeks to ensure compliance. Responsible Person: Director of Pharmacy	November 3, 2014 December 15, 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A749	The IV room IC policy directed that barrier isolator gloves will be changed every other day. 3. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items on the antechamber of isolator #3, sprayed the antechamber with sterile 70% isopropyl alcohol and after donning the isolators gloves/sleeves and a 20 second lapse in time, moved the items from the antechamber to the main chamber. Interview with Pharmacy Technician #1 on 10/27/14 at 2:08PM noted that, after the antechamber and items therein were sprayed with the alcohol solution, items remained in the antechamber for as long to don the isolator gloves/sleeves, enter the main chamber and transfer the items. Interview with the Director of Pharmacy on 10/27/14 at 2:05PM noted that items needed to remain in the antechamber for 15-20 seconds after the isopropyl alcohol spray. Manufacturer's recommendations for the IV isolators directed that after cleaning and decontamination, the product is to remain in the transfer chamber (antechamber) receiving a sterile shower for a period of not less than 30 seconds prior to moving them to the main working chamber.	A749		

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A749	4. A tour of the pharmacy department was conducted on 10/27/14 at 2:00 PM with the Director of Pharmacy and identified that the facility had three isolators for medication compounding. Review of the annual pharmacy IV competency evaluations identified that all staff received the annual aseptic technique test and challenge kit competency testing in the fall of 2013. The facility IV Room IC policy, revised in 1/2014, directed that all pharmacy personnel must undergo performance evaluations (competencies) including gloved fingertip sampling and medial fill testing every 12 months. Interview with the Director of Pharmacy on 10/27/14 at 2:40PM noted that staff had not yet undergone gloved fingertip sampling as competencies are conducted in the fall. According too USP 797 (2012), all compounding personnel shall successfully complete an initial competency evaluation and gloved fingertips/thumb sampling no less than 3 times before initially being allowed to compound CSPs and re-evaluation shall occur at lease annually.	A749	Applies to tag A749 All Pharmacy Compounding staff has completed glove fingertip competencies. To ensure annual compliance, glove fingertip competencies have been added to the annul Pharmacy IV Compounding competency. Monitoring: Quality Management to review Pharmacy competencies to ensure all staff has completed testing as scheduled annually. Responsible Person: Director of Pharmacy	November 30, 2014 December 12, 2014

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERJSUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
	070016	A BUILDING _____ B. WING	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP CODE
SAINT MARYS HOSPITAL	56 FRANKLIN ST WATERBURY, CT 06706

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A 000	INITIAL COMMENTS	A 000		

The following reflects the findings of the Connecticut Department of Public Healtl1 during an authorized substantial allegation survey concluded on 9l4115 in response to complaint #18731 at:

St Mary's Hospital
54 Franklin St
Waterbury, CT 06706

The following Conditions of Participation were reviewed as they pertained to the complaint:

Governing Body 482.12
QAPI 482.21
Pharmaceutical Services 482.26

Condition level noncompliance was identified under:

Governing Body 482.12
Pharmaceutical Services 482.25

Acronyms and Abbreviations that may be used throughout this document include:

MD Medical Director
NM Nurse Manager
RN Registered Nurse
Pt Patient
Tx Treatment
QAPI Quality Assurance Program Improvement
P&P Policy and Procedure
EM Environmental Monitoring

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | {XQ)DATE

Any deficiency statement ending with an asterisk e) denotes a deficiency which the Institution *may* be excused from correcting providing It Is determined that other safeguards provide sufficient protection to the patients. (See instn1clions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. for nursing homes, the above findings and plans of correction are disclosab!e 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued progran1 participation.

STATEMENT OF DEFICIENCIFS AND PIAN OF CORRECTION	(X1) PROVIOERJSIJPPUERJCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070016	A. BUILDING _____ B. WJNG	C 09/0412015

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SAINT MARYS HOSPITAL	56 FRANKLIN ST WATERBURY, CT 06706

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A 000	Continued From page 1 Definitions: USP-797: United States Pharmacopeia, Chapter 797, Requirements for licensed entities that compound sterile products. BSC: Biological safety cabinet: an enclosed, ventilated lab workspace. LAFW: Laminar flow workbench: where sterile preparations are combined under laminar air flow which is used to exclude contaminants. PEC: Primary Engineering Controls: the environment in which sterile doses of hazardous drugs are compounded. CACI: Compounding aseptic containment isolator, marked as "chemo hood", referenced in certification report. CAI: Compounding aseptic isolator PPE: Personal Protective Eq11lpment: gowns, hair covering, masks, gloves and booties that are worn by.personnel within the area of sterile compounding as directed by USP 797 standards. CFU: Colony Forming Units: a measurement of how large a mold area has grown. Certification of the rooms involve airborne non-viable particle counting (determining of ISO classification), airflow testing and smoke pattern est, room pressurization, HEPA filter leak test, general temperature and humidity. Environmental Monitoring: is a combination of	A 000		

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A 000	Continued From page 2 both the non-viable and viable testing done every 6 months. Non-viable is to determine the ISO classification. Viable testing includes surface and air sampling of the compounding areas including the hoods or PEC's (primary engineering controls). USP 797 Environmental sampling: The ES program should provide information to staff and leadership to demonstrate that the PEG Is maintaining an environment within the compounding area that consistently ensures acceptably low viable and nonviable particle levels. Environmental Sampling data shall be collected and reviewed on a periodic basis as a means of evaluating the overall control of the compounding environment.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION Is not met as evidenced by: Based on observations, a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Governing Body. The findings included: 1. The Governing body did not ensure that services offered and provided met the Medicare Conditions of Participation. Areas of noncompliance identified include: Pharmaceutical	A 043		

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A 043	Continued From page 3 Services. Refer to A·283, A-490, A-492, and A-501. 2. The Governing body failed to function effectively to ensure that culture testing was conducted In the off slte Intravenous (IV) Infusion Center by Company 111 (contracted service) prior to the initiation of compounding medications and/or failed to ensure that the contracted company provided quality services (Refer to A-83) and/or that mold/fungus growth that required the discontinuation of compounding was reported to the Governing body for review. a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold. b. Review of environmental testing completed by company **#1** (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth	A 043	Applies to Tag A 043 (a): Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Fire and Safety Surveyor and the DPH will validate all requirements of USP797 at this location prior to resuming compounding activities. Monitoring: Initial compounding date to be determined once plan for re-opening site is identified. Responsibility: Director of Pharmacy Applies to Tag A 043 (b): Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor. Monitoring: Not applicable	To Be Determined August 21, 2015

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A 043	Continued From page 4 were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3112/15, 4/30/15, and on 5/28115 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion center on that day. Interview with the Director of Pharmacy on 8/18/15 at 10:00 AM indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the surveyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained. c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 1O:1O AM indicated !hat testing within the isolator was only conducted in one area within the unit and in one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797. d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797.	A 043	Responsible Person: Manager of Ambulatory Services Applies to Tag A 043 (c): Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-opening the compounding units. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 043 (d): Environmental company asked to ensure that neutralizing specifications be added to the environmental report. Monitoring: IV Compounding Committee will review all environmental reports as they are submitted. Responsibility: Director of Pharmacy	September 30, 2015 On-going May 28, 2015 On-going

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A 043	Continued From page 5 e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dales from October 2014 lo July 23, 2015. f. On 4/30/15 and 5/28/15 mold was Identified In both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filter upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview. g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was In place to ensure quality services were provided subsequent to the identification of mold growth in the compounding **rooms.** h. In March of 2015 the daily cleaning company was changed to a Company #3, a hospital grade company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the	A 043	Applies to Tag A 043 (e): Environmental company asked to ensure that environmental reports include lot number and expiration dates. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 043 (f): A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The Committee consists of Pharmacy Management, Environmental Services, Facilities Management, Microbiologist, Infection Prevention Physician, Quality Management and Regulatory Compliance. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review. Responsibility: Director of Pharmacy	August 3, 2015 On-going August 26, 2015 On-going

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A 043	Continued From page 6 facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 Indicated that hospital staff provided the terminal cleaning which Included all surfaces in the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly. j. Interview and tour of the compounding rooms with the Director of Engineering on 8/17/15 at 10:45AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for mediations to be stored. Medications were transferred to the main hospital pharmacy on 6/13/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/11/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/14 through 6/30/15 the facility failed to have a mechanism in place to monitor the temperature of the rooms where the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendation. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room.	A 043	Applies to Tag A043 (g, h & i): Competency of contracted cleaning service, including product handling, equipment evaluation and procedure compliance to be completed. Competency of hospital staff of terminal cleaning has been completed. Monitoring: Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative. Responsibility: Director of Environmental Services Applies to A043 (j): Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms. Business plan approved, pending implementation of construction. Policy/procedure completed during survey and approved by CT Consumer Protection surveyor. Monitoring: Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly. Responsible: Manager of Ambulatory Services	Oct 15, 2015 On-going August 28, 2015 August 18, 2015 Decem ber 1, 2015

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A 043	Continued From page 7 Temperatures. k. Interview with the Manager of the Infusion Center and the Director of Engineering identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part that the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital. l. Interview and tour of the compounding rooms on 8/17/15 at 11:00 AM with the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy entitled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted. Interview with the Director of Engineering on 8/20/15 at 4:00 PM identified he was responsible to ensure a thermometer, pressure senor and exhaust fan alarms were present in the positive and negative pressure rooms and a plan for a power outage and did nol. Review of the job description for the Director of Engineering identified his/her responsibilities in part directed the management of the physical plant, electrical and medical gas delivery systems, emergency generators and project	A 043	Applies to A042 (k): Power outage policy developed during on site survey and approved by surveyor from the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management. Monitoring: Pharmacy management and Manager of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur. Responsibility: Manager of Ambulatory Services Applies to A042 (l): Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan. Pending construction implementation. Monitoring: The IV Compounding Committee to ensure the business plan for improvements is implemented. Responsibility: Director of Facilities	August 28, 2015 On-going Date of installation to be determined.

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A 043	Continued From page 8 management. In addition the Director of Engineering supervises general contractors, evaluates locates and recommends equipment and systems for replacement or upgrades, provides oversight for the development and implementation of an overall emergency management strategy for the hospital, applies practical knowledge for the operation of air conditioning and heating systems and meets with contractors to plan, organize, coordinate and communicate programs, services policies and procedures. m. During an interview on 8/18/15 at 10:30 AM, the Director of Pharmacy, the hospital's microbiologist and the Director of Facilities indicated they had meetings each time culture results were received with the Director of Environmental Services to discuss the mold/bacteria issues in the Infusion Center however, documentation did not support this. An interview with the Director of Environmental Services was unable to be scheduled as he was on a medical leave. n. During interview on 8/18/15 at 10:40 AM, the hospital microbiologist and the Director of Pharmacy identified mold issues were discussed at each monthly infection control meeting in the attendance of MD #1 who was the infection control physician. MD #1 indicated on 8/18/15 at 4:39 PM he was not aware that mold even in small amounts exceeded the USP 797 threshold. Further interview with MD #1 and the hospital mlcrobiologist Indicated that speciation was not conducted until January of 2015 and would be important for identification of the bacteria/mold to determine an appropriate action plan. MD #1 and the hospital microbiologist could identify why the	A 043	Applies to A 043 (m): Formal documentation of the meeting of the IV Compounding meeting implemented. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent the subsequent month to the Quality Committee of the Board for review. Responsibility: Manager of Clinical Quality and Regulatory Affairs Applies to A 043 (n): Speciation initiated January 2015. IV Compounding Committee will ensure that the presence of any reported mold, even in small amounts, will have an appropriate plan to address the findings.	August 26, 2015 On-going

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A 043	Continued From page 9 speciation was not conducted from September through December of 2014. Review of the infectious disease physician's duties and responsibilities included to oversee the infection control department. Interview and review *of* the Governing Body Minutes from September 2014 through June 2015 with the Chief Nursing Officer (CNO) on 8/24/15 at 1:00 PM identified the Chief Medical Officer (CMO) presented the report of the Quality and Safety Committee minutes to the Governing body however the minutes failed to reflect any acknowledgement that during that period of time, the hospital's outpatient infusion center had grown mold within the compounding areas that exceeded the USP 797 guidelines. In addition the minutes failed *to* reflect the infusion center ceased compounding on 6/30/15 due to mold in the antechamber *of* the isolator. Further interview with the CNO indicated he did not inform the Governing body of the positive cultures In the infusion center as remediation was in place and although compounding operations ceased on 6/30/15 patient care was not Interrupted. Interview with the CMO on 8/24/15 at 1:10 PM indicated he was not aware that the positive culture results in the infusion center exceeded USP 797 thresholds and/or that compounding had ceased in that area as of 6/30/15. The CMO indicated that he would have expected to be notified. Review *of* the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use of drugs.	A 043	Monitoring: Will ensure that any positive environmental reports require clinical review by the Chief of Infection Prevention with recommendations and action by the IV Compounding Committee. Responsible Person: Director of Pharmacy Applies to A043 (n) con't: Note of correction: the CMO was not interviewed. This should be amended to Chief of Staff (COS) and Chairman of the Quality Committee of the Board. Previously the Director of Pharmacy reported compounding activities quarterly to the Infection Prevention Committee which were documented and the minutes shared with the Governing Board. Immediately, Pharmacy will begin reporting compounding activities monthly to the IP Committee and the minutes will be shared with the Governing Board at the subsequent Board meeting. Monitoring: Infection Prevention minutes to be distributed at the Quality Committee of the Board. Responsible Person: Chief Nursing Officer and Vice President of Quality	On-going September 15, 2015 October 1, 2015

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A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, interviews and policy review, the Governing Body failed to ensure that quality services were rendered by contracted company's to conduct environmental testing and/or certification of the compounding rooms and/or that staff recognized that reports submitted by numerous company's were complete/accurate. The findings included: a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence from September 2014 through December 2014 that the compounding rooms were negative and positive. b. Review of the report dated 8/20/15, submitted by Company #4, to the Director of Engineering identified that the positive pressure room did not meet the minimum requirement in USP797. The room had only 0.012 of pressure and the minimum requirement is 0.02. Also, it was found that the negative pressure room was drawing air Into the room from the return in the ceiling. The Director of Engineering failed to respond to the	A 083	Applies to A 083 (a): The multi-disciplinary IV Compounding Committee will ensure adherence to USP797 protocols. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Negative and positive pressure IV compounding rooms will be tested annually per policy. All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance. Monitoring: IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance. Responsibility: Director of Pharmacy Applies to A 083 (b): Return room duct has been removed from negative pressure room. Monitoring: NA Responsible Person: Director of Facilities	October 7, 2015 On-going September 9, 2015

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A083	Continued From page 11 abnormal report. Review of the certification report test dated 9/2/14, provided the following information: c. As per the manufacturer, there are 2 supply and 2 exhaust HEPA filters (total of four) In the CACI. The test report documented that only leak tested one HEPA filter and listed the exhaust as non-applicable. There was no way to determine if the other three were leak tested before compounding began inside the CACI (chemotherapy hood), *d.* There were two chambers to the isolator with two gauges showing the pressure in each chamber (ante chamber or the pass through and compounding chamber). Only the barrier isolator pressurization or compounding chamber was documented In the certification. e. The pressure measured inside the isolator is listed as 0.34 inches of water column. A CACI Is used for chemotherapy compounding and is a negative pressure isolator as seen in the physical inspection on 8117/15 where the dials for both the chambers read negative pressure. But the report lists the pressure inside as positive pressure and incorrectly lists the manufacturer specifications as 0.01. f. The alarm assessment test is marked as not applicable. Since there is an alarm on the CACI, there is no reason given that it was not tested. g. The certification does not list If it was done under dynamic conditions as required under USP797,	A 083	Applies to A 083 **(c) through (l):** Agreement with former hood Certification Company terminated. New hood certification company agreement in place. In-service of USP797 documentation requirements to take place between hood certifier and IV Compounding Committee. Monitoring: IV compounding Committee to review all certification and environmental reports for accuracy as they are submitted. Responsible Person: Director of Pharmacy	September 15, 2015 September 30, 2015 On-going

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A 083	Continued From page 12 h. Under overall certification, the box for fail is crossed off. The pass box is filled in. There is a note that there is an issue with the units magnehelic gauge which measures the pressure inside the isolator. i. The report shows that 4 HEPA filters were leak tested-2 exhaust and 2 supply filters. According to the manufacturer there is only one supply filler. The certification does not match the manufacturer specifications. j. The alarm assessment test is marked as not applicable. Since there is an alarm on the CAI for low pressure, there is no reason given that it was not tested. k. The pressure lest indicates a negative 0.38 Inches of water column in the barrier isolator and the pass through. This is a CAI which is a positive pressure isolator therefore the pressure should not be negative. Even the manufacturer specifications are listed incorrectly as negative 0.02 for both the chambers_ l. The certification does not list if it was done under dynamic conditions as required under USP797. m. The pre-filters of the isolators are changed every 3 months. The CACI pre-filters are dated 3/25/15 of when they were changed but there is no date on the CAI prefilters. This Is done by an outside vendor that also does changes the fillers in the entire hospital. There is no way to determine when the prefilters at the off-site infusion center were changed since the invoices	A 083	Applies to A 083 (m): All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance. Monitoring: IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance. Responsibility: Manager of Ambulatory Services	October 7, 2015 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
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A 083	Continued From page 13 are done by listing all the filters changed and does not provide specifically where these filters are located. Interview with the Director of Pharmacy on 8/18/15 indicated when the certifications reports were issued, hospital staff failed to identify the aforementioned abnormalities and/or contacted company #5 (certified the isolators). At the time of this inspection, there was no report showing if the CAI had even passed certification when compounding was started on 9/4/15.	A 083		
A 283	482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk. high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas: and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

STATEMENT OF DEFICIENCIES AND PLAN Of CORRECTION	{X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER'	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
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A 283	Continued From page 14 This STANDARD is not met as evidenced by: Based on a review of hospital documentation, interviews and policies, the hospital failed to develop quality performance Improvement activities regarding high risk area's Including the IV infusion center (offsite location). The finding includes the following: The infusion center was opened by the hospital on 9/4/14. Review of environmental testing completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation al the infusion center on that day. a. Review of the Infection prevention committee meeting minutes during the period of September 2014 through June 2015 failed to indicate that surveillance activities were conducted subsequent to the identification of mold growth. Review of the Infection prevention committee functions in part. determines the mechanism for	A 283	Applies to Tag A283: A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Committee The team will be responsible for adherence to USP797 regulations. Monitoring: Activities will be reported to Infection Preventions, Pharmacy & Therapeutics Committee and the Quality Committee of the Board. Responsible Person: Director of Pharmacy	Aug 26, 2015 On-going

STATEMENT OF DIFIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CUA. IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) OATE SURVEY COMPLETED
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A 283	Continued From page 15 effective surveillance for hospital-acquired infections. Cultures would be conducted whenever necessary for environmental or patient surveillance. Recommendations for corrective actions woL1Id be implemented whenever necessary.	A 283		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Pharmaceutical Services. The findings included: 1. The hospital failed to ensure the Pharmacy department was in compliance with federal and state laws (USP-797) and/or that the Director recognized questionable performance standards provided by contracted services that provided environmental testing and certification at the IV infusion center from 9/4/14 through 6/30/15. Refer to A-492 and A-501.	A490	Applies to Tag A 490: A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. The team will be responsible for adherence to USP 797 regulations. Monitoring: Activities will be reported monthly to Infection Prevention, Pharmacy & Therapeutics and Quality Committee of the Board. Responsible Person: Director of Pharmacy	August 26, 2015 On-going
A 492	482.25(a)(1) PHARMACIST RESPONSIBILITIES A full-time, part-lime, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy	A 492		

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A 492	Continued From page 16 services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contractor reports. interviews, and policy review, the hospital failed to provide the necessary supervision of Pharmacy services to ensure that IV compounding rooms were tested/certified in accordance with federal and state laws (USP-797) and/or that culture testing was conducted prior to the initiation of compounding and/or that culture testing was comprehensive and/or that inaccurate reports were recognized and addressed. The findings include: The infusion center was opened by the hospital on 9/4/14. Review of reports completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the IV Infusion Center rooms where compounding was conducted in an isolator identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified In October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room In January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 In the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion	A 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xf) PROVIOER/SUPPL!ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 492	Continued From page 17 center on that day. a. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and inte1View with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold. b. Inte1View with the Director of Pharmacy on 8/18115 at 10:00 AM Indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus when compounding ceased, so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the su1Veyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained. c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18115 at 10:10 AM indicated that testing within the Isolator was only conducted in one area within the unit and In one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797.	A 492	Applies to Tag A 492 (a): Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Life Safety Surveyor and DPH will validate all requirements of USP797 at this location prior to resuming compounding activities. Monitoring: Initial compounding date to be determined once plan for re-opening site is identified. Responsibility: Director of Pharmacy Applies to Tag A 492 (b): Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor. Monitoring: Not applicable Responsible Person: Manager of Ambulatory Services Applies to Tag A 492 (c): Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-operationalizing the compounding units.	To be determined August 25, 2015 September 30, 2015

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A 492	Continued From page 18 d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797. e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dates from October 2014 to July 23, 2015. f. On 4/30/15 and 5/28/15 mold was identified in both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filler upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview. g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth In the compounding rooms. h. In March of 2015 the daily cleaning company was changed to a company #3, a hospital grade	A 492	Con't Tag A 492 (c): Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 492 (d): Environmental company asked to ensure that neutralizing specifications added to the environmental report. Monitoring: IV Compounding Committee will review all environmental reports as they are submitted. Responsibility: Director of Pharmacy Applies to Tag A 492 (e): Environmental company asked to ensure that environmental reports include lot number and expiration dates. Monitoring: Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly. Responsibility: Director of Pharmacy Applies to Tag A 492 (f): A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any	On-going August 3, 2015 On-going August 3, 2015 On-going August 26, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 492	Continued From page 19 company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms. i. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 indicated that hospital staff provided the terminal cleaning which included all surfaces In the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly. j. Interview and tour of the compounding rooms with Ithe Director of Pharmacy and the Director of Engineering on 8/17/15 at 10:45 AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for medications to be stored. Medications were transferred to the main hospital pharmacy on 6/30/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/1/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/15 through 6/30/15 the facility failed to have a mechanism In	A 492	Cont Tag A 492 (f): business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The IV Compounding Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Monitoring: All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review. Responsibility: Director of Pharmacy Applies to Tag A492 (g, h & i): Competency of contracted cleaning service complete, including product handling, equipment evaluation and procedure compliance. Competency of hospital staff performing terminal cleaning of IV compounding rooms completed. Monitoring: Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative Responsibility: Director of Facilities Applies to A492 (j): Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms pending business plan implementation. Policy/procedure completed during survey and approved by CT Consumer Protection surveyor.	On-going October 15, 2015 September 30, 2015 August 18, 2015

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A 492	Continued From page 20 place to monitor the temperature of the rooms were the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendations. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room Temperatures. k. interview with the Director of Pharmacy, the Manager of the Infusion Center and the Director of Engineering Identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part U1at the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital. I. Tour of the compounding rooms on 8/17/15 at 11:00 AM and interview with the Director of Pharmacy and the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy titled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted. Review of the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use	A 492	Cont' A 492 (j): Monitoring: Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly. Responsible: Manager of Ambulatory Services Applies to A492 (k): Power outage policy developed during on site survey and approved by surveyor form the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management. Monitoring: Pharmacy management and Manger of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur. Responsibility: Manager of Ambulatory Services Applies to A492 (I): Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan implementation. Pending construction implementation. Monitoring: The IV Compounding Committee to ensure the business plan for improvements is implemented.	December 1, 2015 August 28, 2015 On-going Date of installation to be determined .

PRINTED: 091211 2015
FORM APPROVED
OMB NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 492	Continued From page 21 of drugs_ Review of the job description for the Director of Pharmacy included in part the initiative to acquire knowledge, to stay currently Informed in the area and fields which are applicable to this position. Works collaboratively with other departments to meet the needs of the hospital.	A492		

EXHIBIT S4

POLICY #425.1

Subject: Saint Mary's CARE Policy

Effective Date: July 1, 2013

Revised: August 19, 2015

Replaces: Saint Mary's Financial Assistance Policy (FAP)

PURPOSE

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their ability to pay. The underlying theory is that a person, for a reasonable period of time can only be expected to pay a maximum percentage of their disposable income towards charges incurred. Any "self-pay" balance in excess of this amount would place an undue financial hardship on the patient or their family and "may" be adjusted off as Financial Assistance.

POLICY

Recognizing its charitable mission, it is the policy of the hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. Discounted care will be provided to uninsured or underinsured patients who meet the established eligibility criteria and complete the required application (all components in a timely manner) and review process.
All emergency and medically necessary services provided by this facility will be available as uncompensated services.

1. All self-pay accounts will be eligible for 40% self-pay discount, off of the published charges, regardless of their income or assets. Accounts must be in the Self-Pay Financial Class for the discount to be taken.
2. All self-pay accounts could be eligible for 100% discount if the household income is less than 200% of the Federal Poverty Level.
3. In addition to the 40% discount stated above, self-pay accounts may be eligible for an additional 25% discount, up to a maximum of 65%, if their income falls between 200% – 400% of the Federal Poverty Income level.
4. Elective cosmetic procedures are not eligible for charity care.
5. Insured patients with balances, due to deductibles, co-payments, or co-insurance, non-covered charges may be eligible for charity care if their income falls between 200% - 400% of the Federal Poverty Level.
6. Self-pay patients could be eligible for charity care write-offs based on their "Propensity to Pay".

7. A patient may only request Charity Care while the account is still active receivable.
8. Incomplete applications and falsified applications will not be considered eligible for Charity Care.
9. Patients gross income and family size will be considered in determining eligibility for Charity Care.
10. Patients found eligible for Charity Care will be eligible for care for any balance due at the time of application approval and any medically necessary services within the six months prior to application approval date and six month post date of application approval.
11. Charity Care will be given at 400% of the Federal Poverty Income levels. A sliding fee scale will be applied between 200% - 400% of the Federal Poverty Income levels.
12. Signage (in 48 or 72 font) and one page summary describing STMH charity care policy will be in English, Spanish, Portuguese, and Albanian, and placed in Registration, Emergency Department, all Social Services departments, Patient Financial Services (PFS), Cashiers office, Financial Advocate work area, and the Lobby.

DEFINITIONS:

Self-Pay
Self-pay patient is one who is financially responsible, either personally or as a guarantor, for the payment of the charges associated with the health care services provided by Saint Mary's Hospital.

Medical Necessity
Medical Necessity is, hospital care that is rendered either inpatient or outpatient, in order to diagnose, alleviate, correct, cure, or prevent the worsening or onset of a condition that endangers, could result in suffering or pain or may cause malfunction or aggravate a handicap.

Emergency Care
Emergency Care is immediate care provided to avoid causing serious jeopardy to patient's health, or causing serious impairment to body that could result in dysfunction of any organ or body parts.

Amount Generally Billed
Amount Generally Billed (AGB), means the amount generally billed to insured patients for emergent or medically necessary care as determined by the hospital's published charges at the time of billing multiplied by the hospital's most current relationship of costs to charges as taken from the hospital's most recent annual financial filing with the Office of Health Care Access.

Uninsured Patient
Saint Mary's Healthcare (SMH) defines an Uninsured Patient as:

a. Whose income is between 200% - 400% of the Federal Poverty Income levels;
b. Who has applied and been compliant in the eligibly process and has been denied eligibility for any medical or health care coverage;
c. Who is not eligible for coverage under Medicare, Tricare, or any other Federal programs, or privately sponsored health or accident insurance, including, but not limited to, workers' compensation, settlements or judgments arising from suits, claims or proceedings involving motor vehicle accidents or alleged negligence; and
d. Who is liable for one or more hospital charges.

Charity

Charity is the demonstrated inability of a patient to pay. Charity care does not include bad debt, contractual adjustments, or unreimbursed costs from other community services. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt. If the patient is able but unwilling to pay, the hospital will classify the account as bad debt.

Bad Debt
Bad debts are the unwillingness of the patient to pay. It may be included in charity care, provided the patient meet the Federal Poverty Income guidelines and provides the necessary documents, to support the income levels.

Earned Income
Earned income is the sum of all household wages or salaries received on weekly, monthly, or yearly bases.

Catastrophic Illness
Catastrophic illness is any medical condition, either acute or chronic, which incurred expenses that are not fully covered by private insurance, state, federal programs, or other sources. This will also include expenses that exceeded the patient's maximum benefits. Patient will be eligible for discount consideration, as catastrophic, if their outstanding balance exceeds 25% of their gross monthly income.

Propensity to Pay
This is the verification of patient's Ability to Pay their medical bill, based on their estimated income, and their Likelihood to Pay, based on their credit score risk. These two indicators are combined to determine appropriate financial clearance.

PROCEDURE:

1. Charity and discounted care include services provided to the following:
    a. Uninsured or underinsured low-income patients who do not have the ability to pay all or part of their bill as determined by the financial guidelines in this policy;
    b. Insured patients whose coverage is inadequate to cover a catastrophic situation;
    c. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large (as defined earlier in the definitions section) medical bills; and
    d. Patients deemed medically indigent by virtue of their documented eligibility for Medicaid benefits.

2. For emergency and medically necessary services provided to uninsured patients, and whose income are between 200% - 400% of the Federal Poverty Income Levels, SMH will reduce their bill in accordance with the guidelines provided by IRS 501(r)(5).

3. The following factors are to be considered when determining the amount of charity service for which a patient is eligible at the time of service:
    a. The patient's individual or family income, as appropriate, using the income guidelines as published by the Federal Government on April 1 each year (Federal Income Guidelines;
    b. Family size; and
    c. All other resources must be applied first, including third-party payers, Victims of Crime (i.e., a state-level program for crime victims to recover some hospital costs), and

Medicaid. If a patient does not have Medicaid but would qualify, he or she must cooperate with the application process. If the application is denied or is identified as ineligible based on the Medicaid income criteria, consider for charity and discounted care.

d. Propensity to Pay will be run as deemed necessary to qualify for charity care.

4. Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. Note: A third party might pay part of an account, the patient may pay part, and another part might meet charity services. If the patient does not pay the amount deemed to be his or her responsibility, the uncollectible remainder would become bad debt.

5. Require evidence of eligibility. Documentation should be submitted within 14 days from the date of service (to include before and after the date of service). Additional time for completion of the application process may be extended as appropriate. The patient must provide supporting documentation of income, which can include the following:
    a. Paycheck, Social Security, pension, unemployment or disability check stubs, tax return, or other proof of income.
    b. The patient must sign the charity form.

6. Charity-care provisions will be reevaluated for a patient's eligibility when the following occur, it is the patients responsibility to bring this data forth to STMH for consideration:
    a. Subsequent rendering of services;
    b. Income change;
    c. Family size change;
    d. When any part of the patient's account is written off as a bad debt or is in collections; and
    e. When six months have passed since the last application or when circumstances change, whichever comes first.

7. Determine eligibility for charity service at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.

8. Individuals who have questions about SMH charity care policy, or would like assistance with completing the application may contact our financial counselors, either in person, or by calling 203-802-8265.

9. Financial Counselors will initiate and approve/deny the application prior to submitting to the appropriate manager, based on account balance (See Number 11).

10. Patients will be notified in writing within 3 business days (Monday - Friday), from the date the "COMPLETED" application is received, regarding qualification for charity care, the remaining balance due, and any expected re-payment terms.

11. Financial Counselors will determine the write-off amount based on the aforementioned guidelines and the correct contractual allowance code. If the patient does not meet the financial criteria but has extenuating circumstances such as catastrophic illness, the account will be referred to the supervisor who will make a recommendation to the Manager/Director. Charity and discounted care

approval authority is as follows:

a. Write-offs from $.01 to $1,000 require approval by the appropriate Financial Advocate handling the account;
b. Write-offs from $1001 to $9,999 require approval by the Supervisor of Patient Access;
c. Write-offs from $10000 to $19,999 require approval by the Manager of Patient Access;
d. Write-offs $20,000 to $49,999 require approval by the Director of Patient Access;
e. Write-offs greater than $50,000 require approval by the Chief Financial Officer or Director of Finance.

12. Financial Counselors staff will ensure that patients and physicians are notified, in writing, regarding approval, denial, or pending status of uncompensated care. The notification will include the appeal process for any denied application.

13. The appeal process for denied charity and discounted care applications includes the following activities:
    a. Prompt notification of the denial and the specific reasons will be provided to each charity and discounted care applicant. The notification will also provide examples of additional information, which may be used to appeal the denial. Upon notification of the denial, the charity applicant will have 30 days to appeal the decision from the date of the denial letter.
    b. Additional information will be accepted by the provider and re-evaluated by the Supervisor/Manager.
    c. If the initial denial is upheld, prompt notification will be provided to the applicant.
    d. The Director of Patient Access or Director of Finance will review all denied appeals over $50,000. A written determination will be issued within 15 days of the receipt of the appeal.

14. The hospital will retain all charity and discounted care applications and supporting documentation within scanning for seven years.

15. The hospital will update the income eligibility criteria annually, April, using the Federal Poverty Guidelines (FPG) published by the Centers for Medicare & Medicaid Services (CMS). If CMS issues more than one update, the updated criteria shall become effective as of the issue date.

16. The base level for the charity and discount care income eligibility will be set at 40%.

17. Saint Mary's provides free x-rays and basic lab services, for patients that receive primary care services from the Malta House Van. Eligible patients are given a "Malta House" card. These services are written off at the time of billing. If patients are referred to SMH, under Malta House, for other services, they will be asked to complete a financial assistance application and if they are eligible for charity care, the charges will be adjusted appropriately. In order to prevent any billing statements being generated to these patients, a "hold" will be place on these accounts until the charity care determination is made.

18. A charity and discounted care budget will be established once a year during the annual budget process and submitted to the Board of Directors of Saint Mary's Hospital for approval. However, need for financial assistance will take priority over a fixed budget amount; the Board will be

promptly advised if charity and discounted care needs exceed the current budgetary provisions. A formal appeal process shall be implemented to permit rapid review of all appealed charity denials. The Director of Patient Access or Director of Finance shall review all final appeals of charity determinations.

References

The AHA Board of Trustees Statement of Principles and Guidelines on Hospital Billing and Collection Practices (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf);

Internal Revenue Code Section 501® requirements for tax-exempt hospitals (http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120716-legal-adv.pdf).

Creation Date: September 1, 2004
Revision Date: August 19, 2015
Key Content Expert:
JCAHO Reference:

EXHIBIT A: FINANCIAL ASSISTANCE APPLICATION

Saint Mary's HOSPITAL

Patient Name : _____ Date: _____

Current Address: Street_____

City, State, Zip _____

Phone # _____

Account(s)#: _____

Employer's Name & Address: _____

Spouse's Employer and Address: _____

Medical Insurance:_____ Policy/Claim#: _____

Insurance Company Name: _____

Address: _____

Number of Dependents (list ages, including self): _____

_____

Monthly Income (List source/amount): Patient's income_____

Spouse's income _____

Other income_____

I hereby attest that the above information is true and accurate. I understand that in order for me to be eligible, th information contained herein must be verified. I agree to provide Saint. Mary's Hospital with the necessary verifications, and, if requested by the Hospital, I agree to cooperate and follow through with application for State and/or Federal assistance as well as any other third party payors.

Patient/Guarantor: _____ Date: _____

Financial Counselor: _____ Approved by: _____ Date:_____

- All income must be verified. Please provide last 4 pay stubs.
- If you are self-employed, please provide a complete copy of last year's filed Income Tax Return (including ALL schedules (i.e. for example, Schedule C).

*Please note we will notify physicians who are part of the Franklin Medical Group of your eligibility.

Appendix B

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

Appendix C

Sliding Scale Discount Guidelines

1. Less than 200% FPL - 100%
2. 200% – 400% FPL - 65%
3. Greater than 400% - 40%

APPENDIX D: PARAGON ADJUSTMENT CODES

TYPE	CODE	DESCRIPTION	Charity or Free Care
A	48820	REDUCTION TO COST IP SELF PAY	Charity
A	48830	REDUCTION TO COST OP SELF PAY	Charity
A	48840	FREE SERVICE IP SELF PAY	Charity
A	48853	FREE SERVICE OP SELF PAY	Charity

EXHIBIT S5

Subject: **Self Pay Collection Policy**

Effective Date: 5/1/05

Revised 02/01/13

Replaces: NEW

POLICY

It is the policy of St. Mary's Hospital (SMH) that personnel will review outstanding accounts on a daily basis for timeliness of payment, and that personnel will conduct their collection activity and contact with individual patients with professionalism, courtesy and fairness.

PURPOSE

1. To ensure that policies and procedures exist for the timely and fair collection of all patient balances.

PROCEDURE

1. Admission:

All self-pay patients are interviewed by a financial counselor at the point of service. The Financial Counselor will determine if:

- The patient has any insurances that may have been overlooked;
- There is any third-party liability;
- The patient may be eligible for financial assistance, including but not limited to: Medicaid; HUSKY; a Free-Bed fund; and Charity Care;
- Accounts that are determined to be presumptively eligible for any state assistance will be moved from Self-Pay (SFPY) financial class to Welfare Pending (WLFP) financial class.
- Whenever is it determined that the patient qualifies for Charity Care, Financial Counselor will adjust the balance by the appropriate amount, and any resulting balance will become the patient's responsibility.
- If patient is deemed liable for any balance, a deposit will be requested.
- If charity care determination cannot be made, at the point of service, a deposit equal to 50% of the estimated charges will be required prior to any elective procedure.

In the event that a Financial Counselor is not available at the time of admission, they will attempt to contact patients after reviewing their admission record. Financial Counselors will attempt to visit with the patient if they are still in-house; otherwise they will call the patient's home after the patient is discharged.

2. Collection Follow-Up

A. Statements are sent to patients and/or guarantors who have outstanding balances. The timing and frequency of these statements, for both patients with a monthly payment

arrangement and those without, are based upon the statement table/schedule set up in Paragon.

- All accounts that are registered as SFPY will be transferred to Financial Health Strategies (FHS) for follow –up. SMH has contracted with FHS to operate as our Business Office for self-pay accounts. Accounts will be transferred on a daily basis. (see PARPROC for transferring procedures)
- If we get a letter from a patient quoting the Fair Debt Collection Practices Act, 15 USC 1692c, 805(c):

  (c) Ceasing Communications, "If a consumer notifies a debt collector in writing that the consumer refuses to pay a debt or that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector shall not communicate further with the consumer with respect to such debt..."

  We will notify FHS to:

  1. Stop all activity on the account.
  2. Return the account to SMH and SHM staff will refer the account to our collection agency, with a copy of the letter.

  The collection agency is expected to:

  1. Send the validation notice, to the consumer, stating that a new collector is involved.
  2. Then cease all activity and refer the account to their attorney for suit.

B. Accounts will be manually transferred to a bad debt status if one or all of the following has occurred:

- Account has been returned from FHS as part of their “Return File” marked uncollectible. FHS is required to return all accounts that have reached the timeframe of 90 days, with no payments made in the last 45 days.
- Mail is returned stamped “Moved No forwarding Address” and the account is noted as such in the system;
- There is a system note listed in the follow-up history that the third message level on the monthly statement has been mailed;
- No adequate payment has been made in the last thirty (30) days and the patient is not on a payment plan. Adequate is defined as an amount representing 10% or less of the previous balance due.

C. All attorneys representing patients in liability cases are contacted. If we are assured that the case will be settled within 120 days, the account will not be transferred to bad debt. If the settlement date requirement cannot be satisfied, the account is placed with the TCORS (Tobin, Carberry, O’Malley, Riley& Selinger) law firm so that the hospital’s interest can be protected (see TCORS procedures).

3. Bad Debts:

- Accounts are manually transferred from an active (AR) status to a bad debt status by collection personnel;

- Bad debt files are turned over weekly to a collection agency or collection attorney via electronic transfer on a weekly basis;
- Bad debts may be determined at any time during the life of the account;
- Collection personnel may make a determination to turn over an account to a collection agency at any time during the collection process;
- All accounts with a balance due AFTER a Medicare payment has been received MUST have received a minimum of four (4) patient statements over a period of greater than 120 days, and have NOT had a payment posted to the account within the last 120 days before it can be transferred to bad debt.
- Bad debt accounts for Medicare patients must be sent under a separate file to the collection agencies.

4. Settlements:

- FHS Collectors have been given the authority make settlements on accounts that are considered "reasonable". SMH management reserves the right to withdraw this authority at any time.
- SMH Customer Service personnel may offer attorneys representing patients a 5% discount for payment within thirty (30) days, provided the attorney agrees in writing to accept these terms and to discount their fees by the same amount. Any amount exceeding 5% must be approved by management.
- Occasionally, management will authorize collection personnel to offer higher discounts to patients that have previously agreed to payment plans that have had an outstanding balance for more than three (3) years in an effort to settle the account.

5. Collection Agencies:

- Accounts that are sent to bad debt will be assigned to one (1) of the two (2) agencies currently contracted with St. Mary's.
- Account are assigned based on the following Alpha categories:
  I. A - L - American Adjustment Bureau
  II. M – Z - Parallon
- Accounts can be withdrawn from the agencies at any time (see procedure for "removal of account from bad debt").
- If an account has been turned over to the collection agency for a period greater than fourteen (14) days, any request for payment arrangement or settlement must be forward to the agency.
- Collection agencies are required to returned "uncollectible accounts" that are aged greater than 150 days from the date they were transferred.
- All accounts that are returned from the agencies as uncollectible are to be written off to the following codes**: 48903 – Agency Uncollectible**
  48913 – Agency Uncollectible Medicare

6. St. Mary's Policy for Attachment of Wages & Properties

St. Mary's does not have a written agreement with any of the Collection Agencies, regarding the procedures they must follow for attachment of wages and properties. According to Outsource Group, they follow a generally accepted policy for all clients. This is a summary of their established policy:

- Account received.

- Initial dunning notice issued within 24 hours of placement.
- Phone attempt made to contact patient.
- If contact is made, the following may occur:
    1. If patient is unable to pay (unemployed, no assets, etc) the account is returned or if permission is granted by SMH, it is maintained for later follow up.
    2. If patient is bankrupt, account is closed and returned.
    3. If patient disputes charges, collection activity is suspended and proof requested from the hospital.
    4. If patient request financial assistance, collection activity is suspended and the patient is either mailed a SMH financial assistance application or given phone number to contact SMH for an application. If application is mailed to patient, SMH customer service staff is notified by phone and they are requested to document the account.
    5. If settlement is offered, authorization is sought from SMH.

- If all efforts to contact patient fail, or if patient refuses to pay, and it is verified that patient has income or assets that could be used to satisfy charges, the following steps are taken:
    1. Documentation is made of all collection efforts, including: efforts to contact patient, letters sent, income & asset verified, etc.
    2. Authorization is sought from SMH to proceed with litigation.
    3. After authorization is received, the account, along with the documentation, is forwarded to Attorney's Nathanson & Cipriano; P.O. Box 5516; Hamden, Ct 06518.

Summary of Litigation Procedure Followed by Nathanson & Cipriano's Office:

- Account received and documented. File created.
- First demand letter sent to patient.
- File reviewed and approved by Attorney.
- Signed letter sent to patient and Affidavit of Debt sent to collection agency.
- File is designated for either small claims or civil writ.
- Writ is reviewed and signed by Attorney.
- Writ sent to court; summon and complaint sent to State Marshal for service.
- If patient files an answer, case is scheduled for hearing. SMH is notified of hearing and a representative sent to the hearing.
- If no answer is filed a default judgment is entered.
- Once judgment is received, a payment plan is established in accordance with the court order.
- If patient defaults on payment plan and there is verification of employment, application is made for wage execution.
- If there is verified real estate, a judgment lien is filed. NO FORECLOSURE IS DONE ON ANY JUDGMENT LIEN.

EXHIBIT S5

Return of Organization Exempt From Income Tax

Form **990**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public.

▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning 10/01, 2013, and ending 09/30, 20 14

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization: ST. MARY'S HOSPITAL, INC.

Doing Business As:

Number and street (or P.O. box if mail is not delivered to street address): 56 FRANKLIN STREET

Room/suite:

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

D Employer identification number: 06-0646844

E Telephone number: (203) 709-6111

G Gross receipts $ 279,523,406.

F Name and address of principal officer: CHAD WABLE
56 FRANKLIN STREET WATERBURY, CT 06706-1281

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶ 0928

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.STMH.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1907 M State of legal domicile: CT

Part I Summary

1 Briefly describe the organization's mission or most significant activities: SAINT MARY'S HOSPITAL PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	20.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	16.
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1,886.
6	Total number of volunteers (estimate if necessary)	6	171.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	955,477.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	403,825.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	732,890.	1,607,114.
9	Program service revenue (Part VIII, line 2g)	239,560,411.	248,807,341.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,137,914.	4,893,950.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,876,260.	7,471,863.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	250,307,475.	262,780,268.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	7,850.	0
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	111,272,363.	109,911,511.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	120,659,761.	127,849,647.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	231,939,974.	237,761,158.
19	Revenue less expenses. Subtract line 18 from line 12	18,367,501.	25,019,110.

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	187,262,087.	187,153,109.
21	Total liabilities (Part X, line 26)	137,565,692.	140,389,197.
22	Net assets or fund balances. Subtract line 21 from line 20	49,696,395.	46,763,912.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date: 8/14/15

▶ Chad Wable President & CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: MARY-EVELYN ANTONETTI	Preparer's signature: Mary Evelyn Antonetti	Date: 8/13/2015	Check ☐ if self-employed	PTIN: P00431862
Firm's name ▶ KPMG LLP			Firm's EIN ▶ 13-5565207	
Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608			Phone no. 860-522-3200	

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

JSA
3E1010 1.000

Public Disclosure Copy

Return of Organization Exempt From Income Tax

Form **990**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public.

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OMB No. 1545-0047

2013

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- ☐ Address change
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Doing Business As:

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Room/suite:

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

D Employer identification number: 06-0646844

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G Gross receipts $ 279,523,406.

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56 FRANKLIN STREET WATERBURY, CT 06706-1281

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H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶ 0928

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

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K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

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2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

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	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	250,307,475.	262,780,268.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	7,850.	0
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	111,272,363.	109,911,511.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
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COPY FOR PUBLIC INSPECTION

		Beginning of Current Year	End of Year
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	187,262,087.	187,153,109.
	21 Total liabilities (Part X, line 26)	137,565,692.	140,389,197.
	22 Net assets or fund balances. Subtract line 21 from line 20	49,696,395.	46,763,912.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: MARY-EVELYN ANTONETTI | Preparer's signature: Mary-Evelyn Antonetti | Date: 8/13/2015 | Check ☐ if self-employed | PTIN: P00431862

Firm's name ▶ KPMG LLP | Firm's EIN ▶ 13-5565207

Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608 | Phone no. 860-522-3200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

JSA
3E1065 2.000

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
SAINT MARY'S HEALTH SYSTEM PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY. SEE SCHEDULE O.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 91,381,523. including grants of $) (Revenue $ 139,144,254.)
INPATIENT SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT SAINT MARY'S INPATIENT SERVICES PROGRAM.

4b (Code:) (Expenses $ 88,486,574. including grants of $) (Revenue $ 114,931,820.)
OUTPATIENT SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT THE OUTPATIENT SERVICES PROGRAM.

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 179,868,097.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payable to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response or note to any line in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	167		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .	2a	1,886			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)					
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			3a	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*			3b	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			4a		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			5b		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?			6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			6b		
7	**Organizations that may receive deductible contributions under section 170(c).**					
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			7a		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			8		
9	**Sponsoring organizations maintaining donor advised funds.**					
a	Did the organization make any taxable distributions under section 4966?			9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?			9b		
10	**Section 501(c)(7) organizations.** Enter:					
a	Initiation fees and capital contributions included on Part VIII, line 12	10a				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b				
11	**Section 501(c)(12) organizations.** Enter:					
a	Gross income from members or shareholders	11a				
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b				
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b				
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**					
a	Is the organization licensed to issue qualified health plans in more than one state?			13a		
	Note. See the instructions for additional information the organization must report on Schedule O.					
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b				
c	Enter the amount of reserves on hand	13c				
14a	Did the organization receive any payments for indoor tanning services during the tax year?			14a		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			14b		

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 20		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 16		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6		X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? . . .	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.	12a	X	
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12b	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12c	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	13	X	
13	Did the organization have a written whistleblower policy?	14	X	
14	Did the organization have a written document retention and destruction policy?			
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ KYLE JURCZYK 56 FRANKLIN STREET WATERBURY, CT 06706-1281 203-709-6111

Part VII **Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response or note to any line in this Part VII X

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHAD WABLE	40.00									
PRESIDENT AND CEO	10.00	X		X				755,516.	0	186,789.
(2) JOSEPH CARLSON, II	4.00									
TREASURER	4.00	X		X				0	0	0
(3) REV. MONSIGNOR JAMES COLEMAN	1.00									
VICE CHAIRMAN	4.00	X		X				0	0	0
(4) STEPHEN R. GRIFFIN, ESQ.	4.00									
SECRETARY	4.00	X		X				0	0	0
(5) JEROME SUGAR, M.D.	4.00									
CHIEF OF STAFF THRU 12/31/2013	3.00	X		X				69,625.	0	0
(6) S. MARK ALBINI, M.D.	1.00									
DIRECTOR	2.00	X						49,000.	0	0
(7) GARRETT CASEY	4.00									
DIRECTOR	2.00	X						0	0	0
(8) SISTER DOLORES LAHR	2.00									
DIRECTOR	2.00	X						0	0	0
(9) JOSEPH MENGACCI, ESQ.	4.00									
DIRECTOR	2.00	X						0	0	0
(10) WILLIAM MORRIS	1.00									
DIRECTOR THRU 12/31/2013	4.00	X						0	0	0
(11) MICHAEL O'BRIEN	1.00									
DIRECTOR	1.00	X						0	0	0
(12) DAVID ROBINSON	2.00									
DIRECTOR THRU 12/31/2013	3.00	X						0	0	0
(13) ROBERT ROSCOE	1.00									
DIRECTOR	1.00	X						0	0	0
(14) JAMES C. SMITH	4.00									
DIRECTOR	1.00	X						0	0	0

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) CHRISTINE SULLIVAN, ESQ.	1.00									
DIRECTOR	4.00	X						0	0	0
(16) JAMES UBERTI, M.D.	1.00									
DIRECTOR	40.00	X						0	205,088.	10,027.
(17) THE HONORABLE LINDA WIHBEY	1.00									
DIRECTOR (THRU 12/31/2013)	4.00	X						0	0	0
(18) MICHAEL KARNASIEWICZ, M.D.	1.00									
DIRECTOR	1.00	X						0	0	0
(19) ROBERT MAZAIKA	2.00									
CHAIRMAN (SINCE 1/1/2014)	2.00	X		X				0	0	0
(20) ERIC ALBERT	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(21) ROBERT GUMBARDO, M.D.	4.00									
DIRECTOR (SINCE 1/1/2014)	2.00	X						0	0	0
(22) ANGELA MATTIE	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(23) RICHARD PUGH	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(24) FELIX RODRIQUEZ	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
(25) LAURA ST. JOHN	1.00									
DIRECTOR (SINCE 1/1/2014)	1.00	X						0	0	0
1b Sub-total ▶								874,141.	0	186,789.
c Total from continuation sheets to Part VII, Section A ▶								1,933,407.	644,871.	320,237.
d Total (add lines 1b and 1c) ▶								2,807,548.	644,871.	507,026.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 93

		Yes	No
3	Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	X	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	X	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 64

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) RALPH BECKER	40.00									
CFO (SINCE 1/27/2014)				X				0	0	0
(27) CHARLES FINN	40.00									
COO (SINCE 1/13/2014)				X				0	0	0
(28) MICHAEL NOVAK	40.00									
VP OPERATIONS					X			289,312.	0	39,546.
(29) M. CLARK KEARNEY	40.00									
VP HUMAN RESOURCES						X		249,369.	0	36,662.
(30) JOSEPH CONNOLLY	40.00									
CHIEF MARKETING OFFICER						X		185,357.	0	37,070.
(31) STEPHEN SCHNEIDER, MD	40.00									
CMO	10.00					X		0	439,783.	55,648.
(32) GREG BULLER, MD	40.00									
CHAIRMAN, DEPT. OF MEDICINE						X		255,560.	0	18,765.
(33) ELIZABETH BOZZUTO	40.00									
VP SURGICAL SERVICES						X		290,102.	0	47,790.
(34) ROBERT RILEY, CFO										
CFO (FORMER)							X	226,417.	0	32,847.
(35) SANDRA ROOSA										
VP PATIENT SVC							X	221,872.	0	36,757.
(36) CAROLYN ORRELL										
CIO (FORMER)							X	215,418.	0	5,125.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 93

		Yes	No
3	Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	X	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	X	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII X

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	75,420.			
	e	Government grants (contributions)	1e	531,694.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,000,000.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	Total. Add lines 1a-1f		1,607,114.			
Program Service Revenue			Business Code				
	2a	NET PATIENT REVENUE	900099	248,807,341.	248,807,341.		
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	Total. Add lines 2a-2f		248,807,341.			
	3	Investment income (including dividends, interest, and other similar amounts). ATTACHMENT 2		3,767,233.		-4,499.	3,771,732.
	4	Income from investment of tax-exempt bond proceeds		0			
	5	Royalties		0			
			(i) Real / (ii) Personal				
	6a	Gross rents	1,243,154.				
	b	Less: rental expenses					
	c	Rental income or (loss)	1,243,154.				
	d	Net rental income or (loss)		1,243,154.			1,243,154.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	17,869,855. / 1,172,414.				
	b	Less: cost or other basis and sales expenses	16,697,441. / 45,697.				
	c	Gain or (loss)	1,172,414. / 1,126,717.				
	d	Net gain or (loss)		1,126,717.			1,126,717.
Other Revenue	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from fundraising events		0			
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities		0			
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory		0			
		Miscellaneous Revenue	Business Code				
	11a	CAFETERIA & DIETARY	900099	1,170,616.	1,170,616.		
	b	MEANINGFUL USE	900099	2,840,267.	2,840,267.		
	c	PHYSICIAN MALPRACTICE PREMIUMS		577,645.		577,645.	
	d	All other revenue	812930	1,640,181.	1,257,850.	382,331.	
	e	Total. Add lines 11a-11d		6,228,709.			
	12	Total revenue. See instructions		262,780,268.	254,076,074.	955,477.	6,141,603.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	3,571,513.	1,785,756.	1,785,757.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	82,313,271.	70,130,907.	12,182,364.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	7,194,895.	6,024,732.	1,170,163.	
9 Other employee benefits	10,504,369.	8,795,960.	1,708,409.	
10 Payroll taxes	6,327,463.	5,298,378.	1,029,085.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	1,588,789.	397,197.	1,191,592.	
c Accounting	270,562.	67,640.	202,922.	
d Lobbying	145,704.		145,704.	
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	34,741,140.	21,286,460.	13,454,680.	
12 Advertising and promotion	568,970.	426,727.	142,243.	
13 Office expenses	9,330,115.	6,345,673.	2,984,442.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	13,337,712.	7,924,689.	5,413,023.	
17 Travel	203,873.	122,324.	81,549.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	340,398.	204,239.	136,159.	
20 Interest	1,404,558.	351,139.	1,053,419.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	9,887,837.	2,471,959.	7,415,878.	
23 Insurance	5,478,532.	3,287,119.	2,191,413.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	35,048,979.	31,544,081.	3,504,898.	
b BAD DEBT	10,078,145.	10,078,145.		
c CONSULTING	2,283,360.	1,370,016.	913,344.	
d DUES AND SUBSCRIPTIONS	852,330.	639,247.	213,083.	
e All other expenses	2,288,643.	1,315,709.	972,934.	
25 Total functional expenses. Add lines 1 through 24e	237,761,158.	179,868,097.	57,893,061.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X X

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	28,153,440.	1	24,610,433.
	2	Savings and temporary cash investments	28,942.	2	16,948.
	3	Pledges and grants receivable, net	31,774.	3	95,342.
	4	Accounts receivable, net	28,776,370.	4	26,815,465.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	-260,186.	7	-121,001.
	8	Inventories for sale or use	2,220,053.	8	3,644,672.
	9	Prepaid expenses and deferred charges	1,914,476.	9	2,489,313.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 188,967,766.			
	b	Less: accumulated depreciation — 10b: 129,200,168.	61,043,215.	10c	59,767,598.
	11	Investments - publicly traded securities ATCH 3	18,505,914.	11	20,802,742.
	12	Investments - other securities. See Part IV, line 11	46,720,286.	12	48,928,064.
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	127,803.	15	103,533.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	187,262,087.	16	187,153,109.
Liabilities	17	Accounts payable and accrued expenses	37,596,331.	17	34,904,423.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	21,332,784.	20	19,509,799.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	78,636,577.	25	85,974,975.
	26	**Total liabilities.** Add lines 17 through 25	137,565,692.	26	140,389,197.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ X and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	31,172,558.	27	27,668,208.
	28	Temporarily restricted net assets	2,269,137.	28	2,414,574.
	29	Permanently restricted net assets	16,254,700.	29	16,681,130.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	49,696,395.	33	46,763,912.
	34	Total liabilities and net assets/fund balances	187,262,087.	34	187,153,109.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	262,780,268.
2	Total expenses (must equal Part IX, column (A), line 25)	2	237,761,158.
3	Revenue less expenses. Subtract line 2 from line 1	3	25,019,110.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	49,696,395.
5	Net unrealized gains (losses) on investments	5	-527,000.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-27,424,593.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	46,763,912.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☐

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b	X	

Form 990 (2013)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

Part I **Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)
3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 ☐ An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I b ☐ Type II c ☐ Type III-Functionally integrated d ☐ Type III-Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2013

JSA
3E1210 1.000

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)** (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2013. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(03) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 80,420.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 191,245.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 340,449.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization ST. MARY'S HOSPITAL, INC. | Employer identification number 06-0646844

Part III ***Exclusively*** **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $ _____

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
▶ See separate instructions. ▶ Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures . . . . . ▶ $
3 Volunteer hours . . . . . .

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 . . . . . ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . . . ☐ Yes ☐ No
4a Was a correction made? . . . . . ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? . . . . . ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

	(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		145,704.
j Total. Add lines 1c through 1i			145,704.
2 a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		X	

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

		Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1		
2 Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a Current year	2a	
b Carryover from last year	2b	
c Total	2c	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5 Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

SCHEDULE C - PART II-B - LINE 1I

$1,402 - THE CATHOLIC HEALTH ASSOCATION - ANNUAL MEMBERSHIP DUES

$90,000 - LEGAL FEES RELATED TO LOBBYING

$35,802 - CONNECTICUT HOSPITAL ASSOCIATION - PORTION OF MEMBERSHIP DUES EXPENDED ON LOBBYING

$18,500 - COMPENSATION OF CHIEF MARKETING OFFICER ATTRIBUTABLE TO LOBBYING (APPROXIMATELY 10% OF OFFICER TIME SPENT ON LOBBYING ACTIVITIES)

TOTAL OTHER LOBBYING ACTIVITIES: $145,704

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990.

▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	16,630,000.	15,567,000.	13,783,000.	14,500,000.	13,893,000.
b Contributions					
c Net investment earnings, gains, and losses	1,264,000.	1,768,000.	2,426,000.	-64,000.	1,286,000.
d Grants or scholarships					
e Other expenditures for facilities and programs	756,000.	705,000.	642,000.	653,000.	679,000.
f Administrative expenses					
g End of year balance	17,138,000.	16,630,000.	15,567,000.	13,783,000.	14,500,000.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ 2.6700 %
c Temporarily restricted endowment ▶ 97.3300 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		7,272,019.		7,272,019.
b Buildings		65,301,177.	48,126,290.	17,174,887.
c Leasehold improvements				
d Equipment		115,755,461.	80,754,037.	35,001,424.
e Other		639,108.	319,840.	319,268.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				59,767,598.

Part VII Investments - Other Securities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests	5,181,551.	ATTACHMENT 1
(3) Other		
(A) DONOR & HELD IN TRUST BY OTHER	15,696,295.	FMV
(B) DEBT SERVICE FUND	4,321,505.	FMV
(C) MISCELLANEOUS FUNDS	5,613.	FMV
(D) INVESTMENTS IN JOINT VENTURES	23,723,100.	FMV
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	48,928,064.	

Part VIII Investments - Program Related.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶		

Part IX Other Assets.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO REIMBURSEMENT AGENCIES	782,612.
(3) SELF INSURANCE LIABILITY	3,278,452.
(4) PENSION LIABILITY	72,181,823.
(5) OTHER LONG TERM LIABILITIES	9,463,675.
(6) OTHER LONG TERM DEBT (CAPITAL	268,413.
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	85,974,975.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines 2a through 2d			2e	
3	Subtract line 2e from line 1			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines 2a through 2d			2e	
3	Subtract line 2e from line 1			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information.
Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

PART V, LINE 4

THE INTENDED USE OF THE ENDOWMENT FUNDS IS TO USE THE INCOME GENERATED TO SUPPORT THE MISSION OF THE HOSPITAL. THE HOSPITAL ADOPTED INVESTMENT AND SPENDING POLICIES FOR ENDOWMENT ASSETS THAT ATTEMPT TO PROVIDE A PREDICTABLE STREAM OF FUNDING TO PROGRAMS SUPPORTED BY ITS ENDOWMENT WHILE SEEKING TO MAINTAIN THE PURCHASING POWER OF THE ENDOWMENT ASSETS. THE HOSPITAL FOLLOWS A POLICY OF SPENDING AN AMOUNT THAT APPROXIMATES THE INVESTMENT INCOME EARNED, IN ADDITION TO SPECIFIC PURCHASES OF CAPITAL EQUIPMENT. ACCORDINGLY, THE HOSPITAL EXPECTS ITS SPENDING POLICY WILL ALLOW ITS ENDOWMENT FUNDS TO BE MAINTAINED IN PERPETUITY BY GROWING AT A RATE AT LEAST EQUAL TO THE PLANNED PAYOUTS. ADDITIONAL REAL ENDOWMENT GROWTH WILL BE PROVIDED THROUGH NEW GIFTS AND ANY EXCESS INVESTMENT RETURN.

PART X, LINE 2

THE HOSPITAL IS A TAX-EXEMPT ORGANIZATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS GENERALLY EXEMPT FROM INCOME TAXES. THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS HAVE BEEN PREPARED ON THE BASIS THAT ITS TAX-EXEMPT STATUS WILL BE MAINTAINED.

THE INDEMNITY COMPANY AND PHYSICIAN PARTNERS ARE DISREGARDED ENTITIES. THE TAX CONSEQUENCES OF THEIR OPERATING RESULTS ARE ASSESSED AT THE MEMBER LEVEL.

THE HOSPITAL RECOGNIZES THE EFFECT OF INCOME TAX POSITIONS ONLY IF THOSE POSITIONS ARE MORE LIKELY THAN NOT OF BEING SUSTAINED. RECOGNIZED INCOME

Part XIII Supplemental Information *(continued)*

TAX POSITIONS ARE MEASURED AT THE LARGEST AMOUNT OF BENEFIT THAT IS GREATER THAN FIFTY PERCENT LIKELY TO BE REALIZED UPON SETTLEMENT. CHANGES IN RECOGNITION IN MEASUREMENT ARE REFLECTED IN THE PERIOD IN WHICH THE CHANGE IN JUDGMENT OCCURS. THE HOSPITAL DID NOT RECOGNIZE THE EFFECT OF ANY INCOME TAX POSITIONS IN EITHER 2014 OR 2013.

ATTACHMENT 1

SCHEDULE D, PART VII - INVESTMENTS - CLOSELY HELD EQUITY INTERESTS

DESCRIPTION	BOOK VALUE	COST OR FMV
NET INTEREST IN FOUNDATION	5,181,551.	FMV
TOTALS	5,181,551.	

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 250.0000 %	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other ____%	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			328,346.		328,346.	.14
b Medicaid (from Worksheet 3, column a)			68,868,328.	55,785,133.	13,083,195.	5.75
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			69,196,674.	55,785,133.	13,411,541.	5.89
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			147,207.		147,207.	.06
f Health professions education (from Worksheet 5)			19,733,222.	17,074,901.	2,658,321.	1.17
g Subsidized health services (from Worksheet 6)			3,622,131.	2,236,001.	1,386,130.	.61
h Research (from Worksheet 7)			165,239.		165,239.	.07
i Cash and in-kind contributions for community benefit (from Worksheet 8)			70,911.		70,911.	.03
j Total. Other Benefits			23,738,710.	19,310,902.	4,427,808.	1.94
k Total. Add lines 7d and 7j			92,935,384.	75,096,035.	17,839,349.	7.83

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing			202.		202.	
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			169,504.		169,504.	
9 Other						
10 Total			169,706.		169,706.	

Part III **Bad Debt, Medicare, & Collection Practices**

			Yes	No
Section A. Bad Debt Expense				
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	3,295,553.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	2,306,887.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				
Section B. Medicare				
5 Enter total revenue received from Medicare (including DSH and IME)	5	94,305,076.		
6 Enter Medicare allowable costs of care relating to payments on line 5	6	86,782,623.		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	7,522,453.		
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				
Section C. Collection Practices				
9a Did the organization have a written debt collection policy during the tax year?	9a		X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	H. L. CANCER CTR	OUTPATIENT CANCER TREATMENT	50.00000		
2	HEART CTR OF FW	CARDIAC SERVICES MSO	50.00000		
3	SM INDEMNITY GROUP	INSURANCE COMPANY	100.00000		
4	FRANKLIN MEDICAL	PRIMARY CARE PHYSICIAN PRACT			100.00000
5	DIAGNOSTIC IMAGING	OUTPATIENT IMAGING CENTER	60.00000		
6	NAUGATUCK VALLEY MRI	MAGNETIC IMAGING	48.00000		
7	SM PHYSICIAN PTRS.	ACCOUNTABLE CARE ORG.	100.00000		
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 SAINT MARY'S HOSPITAL INCORPORATED 56 FRANKLIN STREET WATERBURY CT 06706	X	X		X			X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group SAINT MARY'S HOSPITAL INCORPORATED

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)

			Yes	No
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9.	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url):			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[X] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy SAINT MARY'S HOSPITAL INCORPORATED

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 250 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[X] State regulation			
h	[ ] Residency			
i	[ ] Other (describe in Section C)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Section C)			

Billing and Collections

15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* SAINT MARY'S HOSPITAL INCORPORATED

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a [X] Notified individuals of the financial assistance policy on admission
- b [X] Notified individuals of the financial assistance policy prior to discharge
- c [X] Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d [X] Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e [ ] Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	

If "No," indicate why:

- a [ ] The hospital facility did not provide care for any emergency medical conditions
- b [ ] The hospital facility's policy was not in writing
- c [ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d [ ] Other (describe in Section C)

Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a [ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b [ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c [ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d [X] Other (describe in Section C)

21	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
22	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

PART V, LINE 20D

FREE CARE IS PROVIDED FOR UNINSURED INDIVIDUALS WHOSE INCOME IS BELOW 250% OF THE FEDERAL POVERTY INCOME LEVELS. FOR UNINSURED PATIENTS WHOSE INCOME ARE BETWEEN 251% AND 350% OF THE FEDERAL POVERTY INCOME LEVELS, SMH WILL REDUCE THEIR BILL BY SLIDING SCALE DISCOUNT OR TO "COST OF PROVIDING SERVICES", AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OHCA), WHICHEVER IS GREATER.

UNINSURED PATIENTS, WHOSE INCOME RANGE BETWEEN 351% AND 400% OF THE FEDERAL POVERTY INCOME LEVELS, WILL BE ELIGIBLE FOR AN ADDITIONAL CHARITY CARE REDUCTION OF 20% OFF OF THEIR REMAINING ACCOUNT(S) BALANCE(S).

PART V, LINE 3

SAINT MARY'S RECEIVED SIGNIFICANT INPUT FROM PERSONS REPRESENTING THE COMMUNITY. THE ASSESSMENT WAS CONDUCTED IN COLLABORATION WITH THE NEWLY FORMED GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (GWHIP), WHICH INCLUDES SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION. IN ADDITION, GWHIP HOSTED A PRIORITIZATION SESSION THAT INCLUDED 41 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. AT THIS PRIORITIZATION SESSION WHICH TOOK PLACE ON JUNE 18, 2013, THE GROUP VOTED ON COMMUNITY HEALTH PRIORITIES.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

THE SESSION INCLUDED 41 PARTICIPANTS FROM 29 ORGANIZATIONS INCLUDING BUT NOT LIMITED TO WATERBURY BOARD OF PUBLIC HEALTH, CATHOLIC CHARITIES ARCHDIOCES OF HARTFORD, UCONN SCHOOL OF PUBIC HEALTH, END HUNGER CONNECTICUT, VNA HEALTH-AT-HOME, BRIDGE TO SUCCESS, HEART CENTER OF GREATER WATERBURY AND THE CHAMBER OF COMMERCE. A LISTING OF PARTICIPANTS IS AVAILABLE UPON REQUEST.

PART V, LINE 4

WATERBURY HOSPITAL

PART V, LINE 5C

GWHIP HOSTED A "HEALTH SUMMIT" AT NAUGATUCK VALLEY COMMUNITY COLLEGE ON OCTOBER 4, 2013. MEMBERS OF THE PUBLIC WERE INVITED TO ATTEND. OVER 100 PEOPLE ATTENDED THE EVENT.

AT THE HEALTH SUMMIT, GWHIP REPRESENTATIVES PRESENTED THE CHNA FINDINGS. GWHIP ALSO CONVENED WORK GROUPS TO ADDRESS IDENTIFIED AREAS OF COMMUNITY HEALTH NEED.

PART V, LINE 7

SAINT MARY'S HOSPITAL ADMINISTRATORS DECIDED TO FOCUS ON THE TOP FOUR COMMUNITY HEALTH NEEDS (ACCESS TO CARE; MENTAL HEALTH/SUBSTANCE ABUSE; CHRONIC DISEASES (OBESITY, HEART DISEASE, DIABETES, AND ASTHMA); AND TOBACCO USE). THESE NEEDS WERE SELECTED AT THE "PRIORITIZATION SESSION" THAT WAS HELD ON JUNE 18, 2013.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

DUE TO LIMITED TIME AND RESOURCES, SAINT MARY'S IS UNABLE TO ADDRESS EACH IDENTIFIED COMMUNITY HEALTH NEED. COMMUNITY ORGANIZATIONS ARE ADDRESSING THE OTHER IDENTIFIED HEALTH NEEDS. FOR EXAMPLE, THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ARE BOTH ADDRESSING "LOW BIRTH WEIGHT" BABIES THROUGH THE WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITION PROGRAM. THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ADMINISTER THE WIC PROGRAM LOCALLY.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 9

	Name and address	Type of Facility (describe)
1	NAUGATUCK VALLEY SURGICAL CENTER 160 ROBBINS STREET, SUITE 1 WATERBURY CT 06708	SURGICAL CENTER
2	THE HAROLD LEEVER CANCER CENTER 1075 CHASE PARKWAY WATERBURY CT 06708	CANCER CENTER
3	SAINT MARY'S MEDICAL IMAGING CENTER 475 CHASE PARKWAY WATERBURY CT 06708	MRI SERVICES
4	SLEEP DISORDER CENTER 1312 WEST MAIN STREET WATERBURY CT 06708	SLEEP CARE
5	OCCPUATION HEALTH & DIAG. CENTER 146 HIGHLAND AVENUE WATERBURY CT 06708	OCCUPATIONAL HEALTH, OCCUPATIONAL THERAPY, PHYSICAL THERAPY
6	HEART CENTER OF GREATER WATERBURY 1075 CHASE PARKWAY WATERBURY CT 06708	CARDIAC CARE
7	ST. MARY'S HOSP. URGENT CARE - NAUGATUCK 799 NEW HAVEN ROAD NAUGATUCK CT 06770	LAB, RADIOLOGY, URGENT CARE
8	ST. MARY'S HOSP. URGENT CARE - WOLCOTT 503 WOLCOTT ROAD WOLCOTT CT 06716	LAB, RADIOLOGY, URGENT CARE
9	ST. MARY'S MEDICAL ONCOLOGY CENTER 1075 CHASE PARKWAY WATERBURY CT 06708	ONCOLOGY
10		

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 6A

SAINT MARY'S HOSPITAL COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING THE FISCAL YEAR ENDED 9/30/2013. THE CHNA IS ACCESSIBLE BY CLICKING "ABOUT US" AND "HEALTH NEEDS ASSESSMENT BUTTON" ON THE SAINT MARY'S WEBSITE AT WWW.STMH.ORG.

PART I, LINE 7A

MANY PATIENTS WITHOUT INSURANCE DO NOT COMPLETE THE APPLICATION FOR CHARITY CARE. THE HOSPITAL, UPON PERFORMING AN ASSET VERIFICATION, MAKES A DETERMINATION WHETHER THE PATIENT WOULD HAVE QUALIFIED FOR THE CHARITY CARE. DURING 2012, THE COSTS ASSOCIATED WITH THE CHARGES FOREGONE RELATED TO THESE PATIENTS WERE APPROXIMATELY $1,340,000. DURING 2013 AND 2014, A SYSTEM CONVERSION LIMITED THE HOSPITAL'S ABILITY TO UNDERTAKE AN ASSET VERIFICATION. AS SUCH, THESE COSTS ARE CLASSIFIED IN THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS. THE HOSPITAL BELIEVES THAT HAD IT PERFORMED THE ASSET VERIFICATIONS IN 2014, COSTS ASSOCIATED WITH THESE PATIENTS WOULD HAVE BEEN FAIRLY CONSISTENT WITH 2012.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7, COLUMN F

THE PERCENT OF TOTAL EXPENSE IN PART 1, LINE 7, COLUMN (F) IS CALCULATED BY DIVIDING COLUMN (E), NET COMMUNITY BENEFIT EXPENSE, BY TOTAL EXPENSE. THE BAD DEBT EXPENSE OF $10,078,145 WAS SUBTRACTED FROM THE TOTAL EXPENSE VALUE USED TO CALCULATE THE PERCENTAGES IN PART 1, LINE 7, COLUMN (F).

PART I, LINE 7

FOR PART 1, LINE 7 SECTIONS (A) CHARITY CARE AT COST, (B) UNREIMBURSED MEDICAID, (C) UNREIMBURSED COSTS-OTHER MEANS-TESTED GOVERNMENT PROGRAMS THE COSTING METHODOLOGY USED WAS THE COST-TO-CHARGE RATIO USING THE INCOME STATEMENT METHOD. THE COST-TO-CHARGE RATIO WAS DERIVED FROM THE YEAR-END GENERAL LEDGER, CALCULATED BY DIVIDING GROSS EXPENSE (LESS BAD DEBT) MINUS OTHER OPERATING REVENUE BY GROSS PATIENT CHARGES AND APPLIED BY CHARGE LINE APPROPRIATELY. SECTIONS (E) COMMUNITY HEALTH IMPROVEMENT; PORTIONS OF (F) HEALTH PROFESSIONS EDUCATION, (G) SUBSIDIZED HEALTH SERVICES, (H) RESEARCH, AND (I) CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS ARE COMPRISED (EXCEPT FOR CASH DONATIONS AND IN-KIND MATERIAL DONATIONS) OF 1) SUPPLY EXPENSES; 2) PURCHASED SERVICES; 3)

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TUITION WAIVERS; AND 4) THE DIRECT SALARY COSTS FOR STAFF COMPENSATED BY THE HOSPITAL AND SPENT TIME PARTICIPATING IN ACTIVITIES THAT QUALIFY AS COMMUNITY BENEFITS.

THE INTERN, RESIDENT AND FELLOW PORTION OF SECTION (F) HEALTH PROFESSIONS EDUCATION ALSO INCLUDES THE SALARIES, FRINGE BENEFITS AND OTHER EXPENSES OF THE RESIDENCY PROGRAM DERIVED FROM THE GENERAL LEDGER. INDIRECT COSTS WERE ALSO APPLIED. THE COST ACCOUNTING METHODOLOGY WAS USED TO DETERMINE NET COMMUNITY BENEFIT EXPENSE FOR (G) SUBSIDIZED HEALTH SERVICES, WHICH INCLUDE IP AND OP PSYCHIATRY SERVICE LINES AND SERIES/RECURRING.

PART III, LINE 4

THE FINANCIAL STATEMENTS DO NOT HAVE A FOOTNOTE FOR BAD DEBT EXPENSE BUT BELOW IS THE FOOTNOTE FOR THE ALLOWANCE FOR BAD DEBTS.

THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER THEIR FINANCIAL ASSISTANCE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN THEIR ESTABLISHED RATES. BECAUSE THE HOSPITAL DOES NOT ANTICIPATE

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COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. THE HOSPITAL GRANTS CREDIT WITHOUT COLLATERAL TO PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY ARRANGEMENTS. ADDITIONS TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ARE MADE BY MEANS OF THE FOR BAD DEBTS. ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE AND SUBSEQUENT RECOVERIES ARE ADDED. THE AMOUNT OF THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENTAL HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS.

PART III, SECTION A: LINES 2 & 3

THE HOSPITAL USED A COST TO CHARGE RATIO TO CALCULATE THE AMOUNTS RECORDED IN LINES 2 AND 3. WE REASONABLY ESTIMATED THE AMOUNT OF BAD DEBTS THAT WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S CHARITY CARE POLICY, IF THE PATIENTS WOULD HAVE APPLIED OR PROVIDED SUFFICIENT INFORMATION. WE DID NOT INCLUDE THIS AMOUNT IN THE COMMUNITY BENEFIT.

Part VI Supplemental Information

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PART III, LINE 8

THERE IS NO SHORTFALL REPORTED IN LINE 7, THEREFORE, WE DID NOT INCLUDE IN COMMUNITY BENEFIT. WE UTILIZED THE COST TO CHARGE RATIO TO ESTIMATE THE MEDICARE ALLOWABLE COSTS OF CARE.

PART III, LINE 9B

A PATIENT MAY REQUEST CHARITY CARE AT ANY TIME IN THE BILLING AND COLLECTION PROCESS. IF THE HOSPITAL, ITS COLLECTION AGENT, OR ITS ATTORNEY BECOMES AWARE THAT THE PATIENT OR GUARANTOR REQUESTS CHARITY CARE, THE COLLECTION PROCESS WILL BE PROMPTLY DISCONTINUED WHILE THE ELIGIBILITY STATUS OF THE PATIENT OR GUARANTOR REQUESTING ASSISTANCE IS DETERMINED. WHENEVER IT IS DETERMINED THAT THE PATIENT QUALIFIES FOR CHARITY CARE, THE FINANCIAL COUNSELOR WILL ADJUST THE BALANCE BY THE APPROPRIATE AMOUNT, AND ANY RESULTING BALANCE WILL BECOME THE PATIENT'S RESPONSIBILITY.

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PART VI, LINE 2

SAINT MARY'S HAS AN ANNUAL STRATEGIC PLANNING PROCESS THAT IDENTIFIES UNMET COMMUNITY NEEDS WHILE DEPLOYING STRATEGIES TO ADDRESS THESE UNMET COMMUNITY NEEDS AND IMPROVE OUR OVERALL COMMUNITY BENEFIT. SAINT MARY'S ALSO WORKS CLOSELY WITH MANY LOCAL CHARITABLE COMMUNITY SERVICE ORGANIZATIONS TO BOTH IDENTIFY AND ADDRESS COMMUNITY NEEDS.

SAINT MARY'S HOSPITAL (SMH) INDIVIDUAL COMMUNITY BENEFIT PROGRAMS HAVE BEEN DESIGNED TO MEET THE LONG-STANDING NEEDS OF INDIVIDUALS LIVING IN THE SERVICE AREA. TO IDENTIFY NEED, SMH HAS RELIED ON EXISTING LOCAL AND REGIONAL NEEDS ASSESSMENTS INCLUDING: UNITED WAY OF GREATER WATERBURY'S COMMUNITY STATUS REPORT (2013); UNITED WAY'S TEN-YEAR PLAN TO END HOMELESSNESS (2013); THE CENTERS FOR DISEASE CONTROL AND PREVENTION BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (2013); CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STATE HEALTH ASSESSMENT (2013); AND THE CONNECTICUT HEALTH CARE SURVEY (2013) BY THE CONNECTICUT HEALTH FOUNDATION.

IN ADDITION, THE HOSPITAL USES CONNECTICUT HOSPITAL ASSOCIATION (CHA)

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ONLINE TOOLS WHICH INCLUDE THE CHIME DECISION SUPPORT TOOL AND CHIME MAPS TO UNDERSTAND SERVICE AREA NEEDS. THE HOSPITAL USES THE CENSUS BUREAU DATABASES AS WELL AS DEMOGRAPHIC REPORTS AVAILABLE THROUGH CLARITAS DATABASES.

BETWEEN 2012 AND 2013, SAINT MARY'S CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). SAINT MARY'S REACHED OUT TO LOCAL ORGANIZATIONS AND FORMED THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (THE PARTNERSHIP). THE PARTNERSHIP INCLUDES LOCAL NON-PROFIT ORGANIZATIONS (SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION). PARTNERSHIP MEMBERS EACH CONTRIBUTED FINANCIAL RESOURCES TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT.

DATA COLLECTION AND RESEARCH

SAINT MARY'S CONTRACTED WITH HOLLERAN, AN INDEPENDENT RESEARCH AND CONSULTING FIRM LOCATED IN LANCASTER, PENNSYLVANIA, TO CONDUCT RESEARCH IN SUPPORT OF THE CHNA. THE CHNA INCLUDED BOTH QUALITATIVE AND

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QUANTITATIVE DATA COLLECTION METHODS. QUALITATIVE DATA WERE COLLECTED THROUGH BOTH A KEY INFORMANT ONLINE SURVEY AND SIX FOCUS GROUPS. TWO HUNDRED FIVE COMMUNITY LEADERS, PARTNERS AND HEALTH CARE PROVIDERS PARTICIPATED IN THE ONLINE KEY INFORMANT SURVEY. TWO FOCUS GROUPS WITH HEALTHCARE PROVIDERS WERE HELD AT EACH OF THE HOSPITALS; 24 HEALTH CARE PROVIDERS PARTICIPATED. FOUR FOCUS GROUPS WERE HELD AT NEIGHBORHOOD ASSOCIATIONS IN WATERBURY; 33 LOCAL RESIDENTS PARTICIPATED.

QUANTITATIVE DATA WERE COLLECTED THROUGH A STATISTICAL HOUSEHOLD TELEPHONE SURVEY OF 1,100 PEOPLE IN THE SAINT MARY'S SERVICE AREA. THE STATISTICAL HOUSEHOLD SURVEY WAS BASED ON THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) STUDY DEVELOPED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC). THE SURVEY ASSESSED INDICATORS SUCH AS GENERAL HEALTH STATUS, PREVENTION ACTIVITIES (SCREENINGS, ETC.) AND RISK BEHAVIORS (ALCOHOL USE, ETC.). THE RESULTS WERE EXAMINED BY A VARIETY OF DEMOGRAPHIC INDICATORS INCLUDING AGE AND GENDER. SPECIAL ATTENTION WAS GIVEN TO IDENTIFYING THE NEEDS OF UNDERSERVED INDIVIDUALS, INCLUDING LOW-INCOME, MINORITY, AND CHRONIC CONDITION POPULATIONS IN THE SAINT

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MARY'S SERVICE AREA. IN ADDITION TO THE HOUSEHOLD SURVEY, SECONDARY DATA WERE ALSO ANALYZED AS PART OF THE CHNA.

PRIORITIZATION

ON JUNE 18, 2013, THE PARTNERSHIP HELD A PRIORITIZATION SESSION THAT INCLUDED 40 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. THE OBJECTIVES OF THE PRIORITIZATION SESSION WERE TO REVIEW THE RECENTLY COMPILED COMMUNITY HEALTH DATA AND HIGHLIGHT KEY RESEARCH FINDINGS; TO GATHER FEEDBACK FROM THE COMMUNITY REPRESENTATIVES; AND TO PRIORITIZE THE COMMUNITY HEALTH NEEDS BASED ON SELECTED CRITERIA.

ATTENDEES VOTED ON THE TOP FOUR PRIORITY AREAS. THE SELECTED PRIORITIES ARE (1) ACCESS TO CARE; (2) MENTAL HEALTH AND SUBSTANCE ABUSE; (3) CHRONIC DISEASES - OBESITY, DIABETES, HEART DISEASE AND ASTHMA; AND (4) SMOKING.

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IMPLEMENTATION STRATEGY

SAINT MARY'S HOSPITAL DEVELOPED AN IMPLEMENTATION STRATEGY TO ILLUSTRATE SPECIFIC PROGRAMS AND RESOURCES THAT SUPPORT THESE IDENTIFIED COMMUNITY HEALTH PRIORITIES. THE IMPLEMENTATION STRATEGY WAS ADOPTED BY THE SAINT MARY'S BOARD OF DIRECTORS ON SEPTEMBER 12, 2013. THE IMPLEMENTATION STRATEGY IS ATTACHED TO THIS FILING. THE CHNA SUMMARY REPORT AND IMPLEMENTATION STRATEGY ARE ALSO AVAILABLE ON THE HOSPITAL'S WEBSITE (WWW.STMH.ORG).

ONCE THE IMPLEMENTATION STRATEGY WAS CREATED, CONTINUED MONTHLY MEETINGS WITH THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP WERE DONE TO ENSURE TAHT EACH ORGANIZATION STAYED ON TRACK WITH THE NEEDS OF THE COMMUNITY. THERE ARE SEVERAL REPRESENATIVES FROM SAINT MARY'S THAT ATTEND THESE MEETINGS EACH MONTH TO NOT ONLY IMPROVE THE HOSPITAL WITH INCREMENTAL CHANGES, BUT THE GREATER WATERBURY COMMUNITY AS A WHOLE. CONTINUED COLLABORATION AND MANAGEMENT OF THE IMPLEMENTATION STRATEGIES ARE DISCUSSED WITH THE COMMUNITY PARTNERS EACH MONTH.

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PART VI, LINE 3

THERE ARE BROCHURES AND SIGNAGE IN FOUR LANGUAGES INDICATING THAT FINANCIAL ASSISTANCE IS AVAILABLE TO QUALIFIED PATIENTS AND THEIR FAMILIES. SIGNAGE IS LOCATED IN REGISTRATION, EMERGENCY DEPARTMENT, ALL SOCIAL SERVICES DEPARTMENTS, CASHIER'S OFFICE, PATIENT FINANCIAL SERVICES AND THE LOBBY. THE SIGNAGE EXPLAINS THE POLICY AND HOW TO APPLY. IN ADDITION, FINANCIAL COUNSELORS ARE AVAILABLE TO MEET WITH INDIVIDUAL PATIENTS TO ASSIST DURING THE PROCESS.

ALL FAMILIES OF ELIGIBLE CHILDREN, REGARDLESS OF INCOME, RECEIVE CARE COORDINATION SERVICES IN PARTNERSHIP WITH THEIR CHILD'S MEDICAL HOME UNDER THE SAINT MARY'S PROGRAM. FAMILY AND COMMUNITY REFERRALS, DIRECT SERVICES, ADVOCACY AND LINKS TO PARENT SUPPORT SERVICES ARE ALSO PROVIDED. A LIMITED NUMBER OF FAMILIES RECEIVE RESPITE AND CAMP FUNDS. UNINSURED OR UNDERINSURED FAMILIES WHO FALL WITHIN THE TITLE V EXTENDED SERVICE FUNDS ELIGIBILITY GUIDELINES CAN ALSO BENEFIT FROM PAYMENT FOR EXTENDED SERVICES (I.E. DURABLE MEDICAL EQUIPMENT, PRESCRIPTIONS,

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SPECIALTY VISITS, THERAPIES AND SPECIAL NUTRITIONAL FORMULAS).

PATIENT FINANCIAL AID SAINT MARY'S HOSPITAL PROVIDES FINANCIAL ASSISTANCE TO PATIENTS WHO QUALIFY FOR THE HOSPITAL'S "BED FUND" OR OTHER FINANCIAL ASSISTANCE PROGRAMS.

IF A PATIENT IS UNINSURED OR OTHERWISE UNABLE TO PAY HIS OR HER MEDICAL BILLS, HE OR SHE MAY QUALIFY FOR THE HOSPITAL BED FUND. IN ORDER TO QUALIFY, A PATIENT MUST MEET CERTAIN CRITERIA, INCLUDING HAVING A HOUSEHOLD INCOME AT OR BELOW 400% OF THE FEDERAL POVERTY LIMITS.

IF A PATIENT QUALIFIES FOR THE "BED FUND," OR ANY OTHER FINANCIAL ASSISTANCE PROGRAMS, THE PATIENT WILL BE NOTIFIED WITHIN THIRTY (30) DAYS OF RECEIPT OF APPLICATION. IF A PATIENT'S APPLICATION IS DENIED, AN EXPLANATION WILL BE PROVIDED. THE PATIENT MAY REAPPLY AT ANY TIME AND THE APPLICATION WILL BE REASSESSED BASED ON THE AVAILABILITY OF ADDITIONAL FUNDS OR A CHANGE IN THE PATIENT'S FINANCIAL STATUS.

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PART VI, LINE 4

SAINT MARY'S TOTAL SERVICE AREA IS COMPRISED OF 35 ZIP CODES, WHICH INCLUDE THE CITY OF WATERBURY AND 17 SURROUNDING TOWNS. THE PRIMARY SERVICE AREA (WHICH INCLUDES WATERBURY, NAUGATUCK, PROSPECT AND WOLCOTT, CT) HAS A POPULATION OF APPROXIMATELY 165,400. THE SECONDARY SERVICE AREA HAS A POPULATION OF APPROXIMATELY 144,600. THE MAJORITY OF SAINT MARY'S HOSPITAL PATIENTS LIVE IN THE CITY OF WATERBURY WHICH IS PARTICULARLY ECONOMICALLY DISTRESSED. THE MEDIAN HOUSEHOLD INCOME IS $40,867, WHICH IS SIGNIFICANTLY LESS THAN THE OVERALL SERVICE AREA, WHICH IS APPROXIMATELY $69,500. THE UNEMPLOYMENT RATE IN THE CITY OF WATERBURY IN SEPTEMBER 2014 WAS 12.5%. THIS IS HIGHER THAN THE STATE OF CONNECTICUT UNEMPLOYMENT RATE OF 7.8% APPROXIMATELY 35.9% OF THE POPULATION IN WATERBURY SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. THIS IS HIGHER THAN THE STATE OF CONNECTICUT WHERE 23.8% OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. IN ADDITION, 17.1% OF FAMILIES IN WATERBURY HAVE POVERTY STATUS COMPARED TO 6.7% IN CONNECTICUT.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CENTRAL WATERBURY HAS BEEN DESIGNATED A MEDICALLY UNDERSERVED AREA (MUA) AND MEDICALLY UNDERSERVED POPULATION (MUP) BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA). HRSA HAS ALSO DESIGNATED CENTRAL WATERBURY AS A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) FOR PRIMARY MEDICAL CARE, DENTAL CARE AND MENTAL HEALTH.

PART II AND PART VI, LINE 5

SMH'S COMMUNITY BUILDING ACTIVITIES INCLUDE THE FOLLOWING: DISASTER PREPAREDNESS; CONTRIBUTIONS TO THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM; HEALTH CARE ADVOCACY; A VARIETY OF WORKFORCE DEVELOPMENT INITIATIVES INCLUDING LECTURES TO ADDRESS HEALTHCARE WORKFORCE SHORTAGES, RECRUITING MINORITIES AND DIVERSE LANGUAGES, AND SPEAKING TO YOUTH ABOUT CAREERS IN HEALTHCARE; PARTICIPATION IN THE CONNECTICUT HOSPITAL ASSOCIATION'S DIVERSITY COLLABORATIVE; UNITED WAY DAY OF CARING; AND PUBLIC LANDSCAPE ENHANCEMENT AMONG OTHERS. THESE ACTIVITIES PROMOTE HEALTH IN MANY WAYS. THE EFFORTS OF OUR DISASTER PREPAREDNESS COMMITTEE ABOVE AND BEYOND WHAT IS REQUIRED OF THEM HELPS TO PREPARE OUR STAFF AND COORDINATE PLANS WITH OTHER LOCAL AGENCIES (FIRE, POLICE, ETC) IN THE

Part VI Supplemental Information

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EVENT THAT A LOCAL DISASTER WOULD OCCUR. THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM COLLABORATES WITH OTHER LOCAL AGENCIES TO IDENTIFY LEAD HAZARDS IN THE COMMUNITY AND EDUCATE AND TREAT INDIVIDUALS IN AN EFFORT TO PREVENT LEAD HAZARDS THROUGHOUT THE COMMUNITY. A VARIETY OF SMH STAFF ADVOCATE FOR HEALTHCARE REFORM BOTH LOCALLY AND AT THE STATE LEVEL IN AN EFFORT TO IMPROVE ACCESS TO HEALTHCARE AND PUBLIC HEALTH. THE VARIOUS WORKFORCE DEVELOPMENT INITIATIVES ASSURE ACCESS TO HEALTHCARE SERVICES IN OUR COMMUNITY WHILE MAINTAINING HUMAN RESOURCES. BOTH THE UNITED WAY DAY OF CARING AND PUBLIC LANDSCAPE ENHANCEMENT CLEAN UP OUR COMMUNITIES TO PROVIDE A SAFE AND HEALTHY ENVIRONMENT FOR EVERYONE TO WORK, PLAY AND LIVE.

PART II AND PART VI, LINE 5

SAINT MARY'S HOSPITAL OFFERS A VARIETY OF FREE PROGRAMS AND SERVICES THAT ARE SUBSIDIZED BY THE HOSPITAL. FROM MEDICAL AND SURGICAL SERVICES FOR THE UNINSURED AND UNDERINSURED TO HEALTH EDUCATION, SUPPORT GROUPS AND COMMUNITY OUTREACH PROGRAMS, SAINT MARY'S PLAYS AN INTEGRAL ROLE IN THE COMMUNITY WHILE RESPONDING TO THE UNIQUE HEALTHCARE NEEDS OF THE

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RESIDENTS OF GREATER WATERBURY.

EXAMPLES OF SAINT MARY'S MANY COMMUNITY BENEFIT PROGRAMS AND SERVICES PROGRAM, WHICH PROVIDES FREE MAMMOGRAMS FOR WOMEN WHO ARE AGE 40 OR OLDER AND HAVE LITTLE OR NO HEALTH INSURANCE. SAINT MARY'S IS THE ONLY HOSPITAL IN WATERBURY OFFERING THIS PROGRAM, WHICH HAS ASSISTED MORE THAN 2,500 WOMEN SINCE 1995. THE PROGRAM IS OFFERED THROUGH SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER. OTHER EXAMPLES OF SAINT MARY'S COMMUNITY BENEFIT PROGRAMS AND SERVICES INCLUDE SUPPORT GROUPS THAT ARE HOSTED AND SUPPORTED BY THE HOSPITAL FOR PATIENTS SUFFERING FROM ASTHMA AND OUR "BEYOND GRIEF" GROUP PROVIDES BEREAVEMENT SUPPORT FOR ADULTS.

ONE OF THE PROGRAMS THAT HAS HAD AN IMPACT IS CALLED "TEEN GRIEF," WHICH PROVIDES CONFIDENTIAL BEREAVEMENT SUPPORT TO STUDENTS OF LOCAL MIDDLE AND HIGH SCHOOLS. ESTABLISHED BY A PEDIATRIC SOCIAL WORKER FROM SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER IN THE WAKE OF THE TERRORIST ATTACKS OF SEPTEMBER 2001, THIS PROGRAM IS SUPPORTED IN PART BY A GRANT FROM THE J. WALTON BISSELL FOUNDATION. THIS IN SCHOOL PROGRAM ALLOWS TEENS TO COPE

Part VI Supplemental Information

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WITH THEIR GRIEF IN A POSITIVE WAY AND PROVIDES THEM WITH A SAFE PLACE TO EXPRESS THEIR FEELINGS AND LEARN FROM THE EXPERIENCES OF THEIR PEERS. IN ADDITION TO THESE PROGRAMS SAINT MARY'S ALSO HAS SUCCESSFUL PARTNERSHIPS WITH OTHER COMMUNITY ORGANIZATIONS SUCH AS THE GREATER WATERBURY UNITED WAY, WELLPATH BEHAVIORAL HEALTH FOR CHILDREN AND FAMILIES, AND THE MORRIS FOUNDATION, WHICH OFFERS TREATMENT, PREVENTION, EDUCATION, AND RECOVERY SUPPORT FOR INDIVIDUALS WITH SUBSTANCE ABUSE AND BEHAVIORAL HEALTH ISSUES. THE HOSPITAL HAS ALSO FORGED COLLABORATIONS TO BRING WORLD-CLASS HEALTHCARE SERVICES TO THE COMMUNITY THROUGH: - THE HAROLD LEEVER REGIONAL CANCER CENTER, A FREESTANDING 40,000-SQUARE-FOOT FACILITY DEDICATED TO OUTPATIENT CANCER CARE, WHICH IS A JOINT VENTURE PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL; - THE HEART CENTER OF GREATER WATERBURY, WHICH PROVIDES ADVANCED CARDIAC SERVICES, INCLUDING ANGIOPLASTY AND OPEN HEART SURGERY, THROUGH A PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL AND THE UNIVERSITY OF CONNECTICUT HEALTH CENTER/JOHN DEMPSEY HOSPITAL. EXTENDING ITS REACH.

SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER HAS BEEN RECOGNIZED BY

Part VI Supplemental Information

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THE CONNECTICUT LEGISLATURE, STATE CHILD ADVOCACY GROUPS AND THE NATIONAL INITIATIVE FOR CHILD HEALTHCARE QUALITY AS A LEADER AND MODEL PRACTICE IN THE CARE OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS BASED ON ITS "MEDICAL HOME" MODEL OF CARE.

FORMALLY KNOWN AS THE NORTHWEST REGIONAL MEDICAL HOME SUPPORT CENTER, THIS HOSPITAL-BASED PROGRAM PROVIDES ASSISTANCE TO CAREGIVERS OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS AND HAS EXPANDED TO FIVE LOCATIONS: SAINT MARY'S CHILDREN'S HEALTH CENTER, LITCHFIELD COUNTY PEDIATRICS IN TORRINGTON, PEDIATRIC ASSOCIATES OF WESTERN, CT, PEDIATRIC ASSOCIATES OF CT AND THE MEDICAL/PEDIATRICS RESIDENCY TRAINING PROGRAM OPERATED JOINTLY BY SAINT MARY'S HOSPITAL AND YALE-NEW HAVEN HOSPITAL.

THE PROGRAM PROVIDES:

- CARE COORDINATION
- FAMILY SUPPORT
- ADVOCACY
- TITLE V FUNDS

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O BENEFITS COORDINATION

WORKING WITH CAREGIVERS, THE "MEDICAL HOME" PROGRAM HELPS CREATE CUSTOMIZED CARE PLANS AND BRINGS TOGETHER RESOURCES THAT FAMILIES WITH CHILDREN OF SPECIAL NEEDS DEPEND UPON. THE PROGRAM PARTNERS WITH PEDIATRIC CARE PROVIDERS TO MEET THE DIVERSE NEEDS OF CAREGIVERS AND FAMILIES OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS. WORKING THROUGH REHABILITATION AND SCHOOL SERVICES, COMMUNITY AGENCIES AND DEPARTMENT OF SOCIAL SERVICES, THE PROGRAM ESTABLISHES TRANSITION PLANS FOR CHILDREN LEAVING THE PROGRAM AT AGE 21. THE UNITED STATES MATERNAL AND CHILD HEALTH BUREAU DEFINES CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN) AS THOSE WHO HAVE OR ARE AT INCREASED RISK FOR: CHRONIC PHYSICAL, DEVELOPMENTAL, BEHAVIORAL OR EMOTION CONDITIONS (EXPECTED TO LAST AT LEAST A YEAR); AND THOSE WHO REQUIRE HEALTH AND RELATED SERVICES OF A TYPE OR AMOUNT BEYOND THAT REQUIRED BY CHILDREN GENERALLY. EIGHTEEN PERCENT OF CHILDREN IN THE UNITED STATES ARE INCLUDED IN THAT DEFINITION.

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IN ADDITION TO THE COMMUNITY BUILDING ACTIVITIES IDENTIFIED IN RESPONSE TO QUESTION 5 AND THE QUANTIFIED FREE OR DISCOUNTED HEALTH SERVICES IDENTIFIED IN THE REPORTED CHARITY CARE FIGURES, SMH PROVIDES OTHER COMMUNITY BENEFITS. EXAMPLES INCLUDE SCREENINGS, LECTURES, HEALTH FAIRS, SUPPORT GROUPS, CONSULTATIONS, REFERRALS TO OUTSIDE AGENCIES AND OTHERS.

HEALTH PROFESSIONS EDUCATION: SMH IS A TEACHING HOSPITAL AND IS COMMITTED TO PREPARING FUTURE HEALTHCARE PROFESSIONALS. THIS CATEGORY REPRESENTS THE MAJORITY OF SMH'S COMMUNITY BENEFIT ACTIVITIES AND INCLUDES EFFORTS TO GENERATE INTEREST IN HEALTH PROFESSIONS AS WELL AS PROVIDING A CLINICAL SITE FOR MEDICAL STUDENTS, HIGH SCHOOL STUDENTS AND COLLEGES FOR STUDENTS WHO ARE PURSUING DEGREES AS NURSES, PHYSICIAN ASSISTANTS (PA), OCCUPATIONAL, SPEECH AND PHYSICAL THERAPISTS, DENTAL HYGIENISTS, RADIOLOGY TECHNOLOGISTS AND MORE.

SUBSIDIZED SERVICES: SMH PROVIDES HEALTH SERVICES TO PATIENTS WITH NO INSURANCE OR STATE INSURANCE INCLUDING EMERGENCY SERVICES AND BEHAVIORAL

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HEALTH CLINICS.

FINANCIAL AND IN-KIND CONTRIBUTIONS: SMH FINANCIALLY SUPPORTS OTHER COMMUNITY ORGANIZATIONS THROUGH SPONSORSHIPS AND IN-KIND DONATIONS VIA TIME SPENT BY STAFF IN THE COMMUNITY ON LOCAL BOARDS AND VOLUNTEERING TIME FOR LOCAL ORGANIZATIONS.

COMMUNITY BENEFIT OPERATIONS: THE COSTS ASSOCIATED WITH PLANNING AND OPERATING COMMUNITY BENEFIT PROGRAMS ARE IN ITSELF A BENEFIT TO THE COMMUNITY. THIS CATEGORY ALSO INCLUDES COSTS ASSOCIATED WITH CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT AS WELL AS DEVELOPING AN IMPLEMENTATION STRATEGY.

RESEARCH

STATE CANCER REGISTRIES ENABLE PUBLIC HEALTH PROFESSIONALS TO BETTER UNDERSTAND AND ADDRESS CANCER. SUCH INFORMATION IS ESSENTIAL FOR IDENTIFYING WHEN AND WHERE CANCER SCREENING EFFORTS SHOULD BE ENHANCED AND FOR MONITORING THE TREATMENT PROVIDED TO CANCER PATIENTS. IN

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ADDITION, RELIABLE REGISTRY DATA IS FUNDAMENTAL TO A VARIETY OF RESEARCH EFFORTS, INCLUDING THOSE AIMED AT EVALUATING THE EFFECTIVENESS OF CANCER PREVENTION, CONTROL OR TREATMENT PROGRAMS. THE DATA IS REPORTED TO A CENTRAL STATEWIDE REGISTRY FROM VARIOUS MEDICAL FACILITIES INCLUDING HOSPITALS, PHYSICIANS' OFFICES, THERAPEUTIC RADIATION FACILITIES, FREESTANDING SURGICAL CENTERS AND PATHOLOGY LABORATORIES. DURING FISCAL YEAR 2014, THE TOTAL COST ASSOCIATED WITH THE SAINT MARY'S HOSPITAL CANCER REGISTRY WAS $165,239.

PART VI, LINE 6

SAINT MARY'S HOSPITAL PLAYS AN INDISPENSABLE ROLE IN THE HEALTHCARE DELIVERY SYSTEM FOR THE GREATER WATERBURY COMMUNITY AND THE TOWNS OF THE CENTRAL NAUGATUCK VALLEY. FOUNDED IN 1907 BY THE SISTERS OF SAINT JOSEPH OF CHAMBERY, SAINT MARY'S HAS BEEN THE CATHOLIC BEACON OF HEALING AND HOPE IN THE COMMUNITY FOR 100 YEARS. BUILT IN THE HEART OF THE CITY AND WITHIN CLOSE DISTANCE OF ITS ONCE-THRIVING BRASS MILLS SO THAT IT COULD RESPOND READILY TO INJURED WORKERS, THE HOSPITAL HAS EVOLVED INTO A DIVERSE HEALTH SYSTEM THAT TODAY PROVIDES A VARIETY OF HEALTHCARE,

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EDUCATIONAL, FINANCIAL AND OTHER BENEFITS TO THE PEOPLE IT SERVES.

SMH AFFILIATED ORGANIZATIONS SHARE THE GOAL OF PROMOTING HEALTHY LIVING AND DISEASE DETECTION AND PREVENTION THROUGHOUT THE WATERBURY COMMUNITY.

THE HEART CENTER OF GREATER WATERBURY IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HEART CENTER PROMOTES HEALTHY LIVING AND CARDIOVASCULAR DISEASE DETECTION THROUGH SUPPORT GROUPS, SCREENINGS, COMMUNITY HEALTH BOARD INVOLVEMENT, AND COMMUNITY EDUCATION.

THE HAROLD LEEVER CANCER CENTER IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HAROLD LEEVER CANCER CENTER PROMOTES CANCER AWARENESS AND SUPPORT FOR PATIENTS THROUGH SUPPORT GROUPS, SCREENINGS AND COMMUNITY EDUCATION.

SAINT MARY'S HOSPITAL FOUNDATION IS A 501(C)(3) WHOLLY OWNED SUBSIDIARY

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COMPANY OF SAINT MARY'S HEALTH SYSTEM. THE FOUNDATION SUPPORTS THE HOSPITAL'S MISSION BY RAISING MONEY TO BENEFIT A VARIETY OF COMMUNITY NEEDS.

FRANKLIN MEDICAL GROUP IS A CAPTIVE PROFESSIONAL CORPORATION OF MULTI-SPECIALTY PHYSICIANS AFFILIATED WITH SAINT MARY'S HOSPITAL. THE MEDICAL GROUP OPERATES THE CHILDREN'S AND FAMILY HEALTH CENTER, DENTAL CLINIC AND A VARIETY OF CLINICS OFTEN BENEFITING THE UNINSURED POPULATION. IN ADDITION TO PATIENT CARE, PATIENTS BENEFIT FROM A VARIETY OF FREE OR DISCOUNTED SERVICES.

PART VI, LINE 7

CT

PART I, LINE 3C

OUTSTANDING PATIENT ACCOUNT BALANCES LABELED AS SELF PAY, MAY BE SENT TO AN OUTSIDE VENDOR FOR VERIFICATION OF ASSETS. PATIENTS THAT ARE CLASSIFIED AS HAVING NO ASSETS WILL BE WRITTEN OFF TO CHARITY CARE.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☐ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a	X	
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Schedule J (Form 990) 2013

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	CHAD WABLE PRESIDENT AND CEO	(i)	537,551.	180,000.	37,965.	151,575.	35,214.	942,305.	32,316.
		(ii)	0	0	0	0	0	0	0
2	JAMES UBERTI, M.D. DIRECTOR	(i)	0	0	0	0	0	0	0
		(ii)	204,314.	0	774.	6,176.	3,851.	215,115.	0
3	ROBERT RILEY, CFO CFO (FORMER)	(i)	225,836.	0	581.	9,211.	23,636.	259,264.	0
		(ii)	0	0	0	0	0	0	0
4	SANDRA ROOSA VP PATIENT SVC	(i)	0	0	221,872.	17,750.	19,007.	258,629.	0
		(ii)	0	0	0	0	0	0	0
5	MICHAEL NOVAK VP OPERATIONS	(i)	231,837.	57,061.	414.	11,700.	27,846.	328,858.	0
		(ii)	0	0	0	0	0	0	0
6	CAROLYN ORRELL CIO (FORMER)	(i)	17,113.	10,000.	188,305.	0	5,125.	220,543.	0
		(ii)	0	0	0	0	0	0	0
7	M. CLARK KEARNEY VP HUMAN RESOURCES	(i)	199,507.	48,644.	1,218.	10,951.	25,711.	286,031.	0
		(ii)	0	0	0	0	0	0	0
8	JOSEPH CONNOLLY CHIEF MARKETING OFFICER	(i)	160,067.	24,959.	331.	9,403.	27,667.	222,427.	0
		(ii)	0	0	0	0	0	0	0
9	STEPHEN SCHNEIDER, MD CMO	(i)	0	0	0	0	0	0	0
		(ii)	351,095.	87,500.	1,188.	11,700.	43,948.	495,431.	0
10	GREG BULLER, MD CHAIRMAN, DEPT. OF MEDICINE	(i)	254,786.	0	774.	15,300.	3,465.	274,325.	0
		(ii)	0	0	0	0	0	0	0
11	ELIZABETH BOZZUTO VP SURGICAL SERVICES	(i)	231,261.	57,288.	1,553.	26,134.	21,656.	337,892.	0
		(ii)	0	0	0	0	0	0	
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Schedule J (Form 990) 2013

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Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J - PART I, LINE 4A

SANDRA ROOSA'S EMPLOYMENT CONTRACT INCLUDED A PROVISION FOR SALARY CONTINUATION. FOR PURPOSES OF SCHEDULE H, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III).

CAROLYN ORRELL RECEIVED A ONE YEAR SEVERANCE PACKAGE. THE AMOUNT IS INCLUDED IN COLUMN B(III).

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SCHEDULE J - PART I - LINE 4B

CHAD WABLE PARTICIPATES IN A 457(F) DEFERRED COMPENSATION PLAN. THE CONTRIBUTION FROM 2008 BECAME VESTED DURING FISCAL YEAR 2014. FOR PURPOSES OF SCHEDULE J, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III). IT IS ALSO LISTED IN COLUMN (F) AS IT WAS PREVIOUSLY REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990.

SCHEDULE J - PART I - QUESTION 6A

EACH SENIOR LEADER IS PROVIDED A BONUS BASED ON NET EARNINGS AND OTHER CORPORATE GOALS. THE BONUS IS CONTINGENT ON CORPORATE GOALS AND OBJECTIVES EACH YEAR. DURING FY2014, THERE WERE 5 OBJECTIVES: PEOPLE,

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SERVICE, QUALITY, FINANCE, AND GROWTH. THE BONUS IS COMPUTED ON A

PERCENTAGE ALLOCATION FOR THE WEIGHT OF EACH OBJECTIVE WHICH IS DIFFERENT

FOR EACH SENIOR LEADER BASED ON THEIR JOB FUNCTION.

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SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

Part I **Excess Benefit Transactions** (section 501(c)(3) and section 501(c)(4) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

	(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total						▶ $							

Part III **Grants or Assistance Benefiting Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part IV Business Transactions Involving Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)	NAUGATUCK VALLEY WOMENS HEALTH	DIRECTOR - M. ALBINI	346,000.	SEE PART V FOR DESCRIPTIO		X
(2)	WEBSTER FINANCIAL SERVICES	DIRECTOR - J. SMITH	505,110.	SEE PART V FOR DESCRIPTIO		X
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information
Provide additional information for responses to questions on Schedule L (see instructions).

PART IV

DR. MARK ALBINI IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HOSPITAL, INC. DURING THE YEAR ENDING SEPTEMBER 30, 2014, THE HOSPITAL PAID DR. ALBINI'S PRACTICE, NAUGATUCK VALLEY WOMEN'S HEALTH, PC, $297,000 IN FEES FOR SERVICE. IN ADDITION, DR. ALBINI WAS PAID $49,000 BY SAINT MARY'S HOSPITAL FOR SERVICES PERFORMED DIRECTLY BY HIM FOR THE HOSPITAL.

MR. JAMES C. SMITH IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HEALTH SYSTEM, WHICH IS THE PARENT HOLDING COMPANY OF SAINT MARY'S HOSPITAL, INC. MR. SMITH IS ALSO THE CHAIRMAN OF WEBSTER BANK. THE HOSPITAL HAS A LINE OF CREDIT THROUGH WEBSTER BANK, THE BALANCE OF THE LINE OF CREDIT AT THE END OF THE REPORTING PERIOD WAS $0. DURING THE YEAR ENDED SEPTEMBER 30, 2014, THE HOSPITAL INCURRED $3,025 IN FEES ON THE LINE OF CREDIT AND PAID $116,016 IN BANKING FEES.

THE HOSPITAL ALSO PAYS WEBSTER FINANCIAL ADVISORS, A COMPANY RELATED TO THE WEBSTER BANK, TO ADMINISTER ITS PENSION PLAN AND OTHER INVESTMENT MANAGEMENT SERVICES. DURING THE YEAR ENDED SEPTEMBER 30, 2014, SAINT

Part IV **Business Transactions Involving Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V **Supplemental Information**
Provide additional information for responses to questions on Schedule L (see instructions).

MARY'S HOSPITAL, INC. AND ITS AFFILIATES PAID $159,316 FOR INVESTMENT MANAGEMENT SERVICES AND $226,753 FOR AMINISTRATION OF THE HOSPITAL'S RETIREMENT PLAN ASSETS.

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ST. MARY'S HOSPITAL, INC.

Employer identification number
06-0646844

990 PART III - LINE 4A

INPATIENT SERVICES SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014, WITH AN AVERAGE LENGTH OF STAY OF 4.23 DAYS. SAINT MARY'S THREE LARGEST PROGRAMS ARE SURGERY, CARDIOLOGY AND MEDICINE.

IN 2014, 867 PATIENTS CHOSE TO HAVE GENERAL SURGERY AT SAINT MARY'S, STAYING AT THE HOSPITAL FOR A TOTAL OF 4,924 DAYS AND GENERATED $14 MILLION IN REVENUE; 1,354 PATIENTS CHOSE SAINT MARY'S FOR CARDIAC CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 5,854 DAYS AND GENERATING $19 MILLION IN REVENUE; AND 4,004 PATIENTS RECEIVED INPATIENT MEDICAL CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 19,158 DAYS, AND GENERATING $39 MILLION IN REVENUE.

AS THE HOSPITAL CONTINUES TO DISTINGUISH ITSELF AS A LEADING PROVIDER OF HEALTHCARE SERVICES IN THE REGION, IT HAS GARNERED RECOGNITION FROM STATE AND NATIONAL ORGANIZATIONS FOR PROVIDING OUTSTANDING PATIENT CARE.

SAINT MARY'S HOSPITAL IS RANKED AS THE TOP-PERFORMING HOSPITAL IN CONNECTICUT FOR DELIVERING PERCUTANEOUS CORONARY INTERVENTION (PCI), A LIFE-SAVING PROCEDURE THAT OPENS THE BLOCKED ARTERIES OF HEART ATTACK PATIENTS. THE NATIONAL STANDARD STATES THAT PATIENTS SHOULD RECEIVE THIS PROCEDURE WITHIN 90 MINUTES OF ARRIVAL AT THE HOSPITAL. ACCORDING TO THE

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FEDERAL CENTERS FOR MEDICARE AND MEDICAID (CMS), 100 PERCENT OF PATIENTS WHO REQUIRE ANGIOPLASTY RECEIVE IT AT SAINT MARY'S WITHIN 90 MINUTES OF ARRIVAL. THIS RANKS SAINT MARY'S AS THE NUMBER ONE PERFORMING HOSPITAL IN CONNECTICUT, AND SIGNIFICANTLY AHEAD OF THE NATIONAL AVERAGE, WHICH IS 79 PERCENT OF PATIENTS BEING TREATED WITHIN 90 MINUTES.

IN ADDITION, SAINT MARY'S IS THE FIRST HOSPITAL IN CONNECTICUT TO RECEIVE A GOLD AWARD UNDER THE AMERICAN HEART ASSOCIATION'S GET WITH THE GUIDELINES PROGRAM FOR ITS TREATMENT OF PATIENTS WITH CORONARY ARTERY DISEASE. IT IS ALSO THE FIRST HOSPITAL IN THE STATE TO RECEIVE A GOLD AWARD FOR ITS TREATMENT OF PATIENTS WITH HEART FAILURE. AS OF FISCAL YEAR 2014, SAINT MARY'S HAS RECEIVED SIX GOLD AWARDS FOR CARDIAC CARE. THESE ACCOMPLISHMENTS ARE INDICATIVE OF THE EXTRAORDINARY CROSS-DISCIPLINE COLLABORATION AND OVERALL COMMITMENT TO CLINICAL EXCELLENCE SHARED BY THE SAINT MARY'S TEAM.

IN THE 2014 FISCAL YEAR, SAINT MARY'S ALSO ACHIEVED THE HIGHEST SCORES IN THEIR ESPECTIVE SIZE/GEOGRAPHIC GROUP EARNING THEM A SPOT ON THE CLEVERLY ASSOCIATES COMMUNITY VALUE 100 LIST FOR BEING A TOP VALUE HOSPITAL. IN ADDITION IN 2014, SAINT MARY'S WAS ONE OF ONLY 712 HOSPITALS IN THE UNITED STATES TO ACHIEVE THE TOP PERFORMER DISTINCTION TWO YEARS IN A ROW FROM THE JOINT COMMISSION.

IN ADDITION, SAINT MARY'S IS A LEADER IN SURGICAL SERVICES. OUR PHYSICIANS PROVIDE BOTH IN-PATIENT AND OUT-PATIENT SURGERY IN THE AREAS

OF GI, ONCOLOGY, THORACIC, VASCULAR, LAPAROSCOPY, TRAUMA, GYNECOLOGY, UROLOGY, NEUROSURGERY, ORTHOPEDICS, CARDIOTHORACIC, PLASTIC, BARIATRIC AND ENDOCRINE SURGERY AT SAINT MARY'S HOSPITAL.

OUR EXPERIENCED SURGEONS PERFORM ADVANCED ROBOTIC-ASSISTED PROCEDURES UTILIZING TWO DAVINCI® ROBOTIC SURGICAL SYSTEMS. THIS INNOVATIVE TECHNOLOGY IS BECOMING THE STANDARD OF CARE FOR MANY COMPLEX SURGICAL PROCEDURES WITH APPLICATIONS FOR GYNECOLOGIC, UROLOGIC, THORACIC, CARDIAC AND GENERAL SURGERY. AS THE LEADING PROVIDER OF SURGICAL SERVICES IN THE REGION, SAINT MARY'S IS COMMITTED TO PROVIDING THE HIGHEST QUALITY AND SUPERIOR SERVICE FOR OUR PATIENTS. DURING FISCAL YEAR 2014, SAINT MARY'S PERFORMED 653 SURGERIES USING THE DAVINCI® ROBOTIC SURGICAL SYSTEMS.

IN ADDITION, THE HOSPITAL OFFERS A COMPREHENSIVE SIX- YEAR TRAINING PROGRAM IN GENERAL SURGERY. SAINT MARY'S HOSPITAL IS COMMUNITY BASED AND BOASTS A CLOSE AFFILIATION TO YALE UNIVERSITY IN NEARBY NEW HAVEN, CONNECTICUT, AND THE UNIVERSITY OF CONNECTICUT IN FARMINGTON, CONNECTICUT. HISTORICALLY, NEARLY ONE HALF OF THE RESIDENTS COMPLETING THIS PROGRAM HAVE PURSUED FURTHER TRAINING IN CARDIOTHORACIC, COLON AND RECTAL, PLASTIC AND RECONSTRUCTIVE, SURGICAL ONCOLOGY, OR VASCULAR SURGERY.

990 PART III - LINE 4B

SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. THE HEALTH SYSTEM'S TWO LARGEST PROGRAMS ARE ITS

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Name of the organization	Employer identification number
ST. MARY'S HOSPITAL, INC.	06-0646844

EMERGENCY DEPARTMENT, WHICH PROVIDED TREATMENT TO 62,335 PATIENTS IN 2014, GENERATING $26 MILLION IN REVENUE, AND AMBULATORY SURGERY. IN 2014, 14,313 PATIENTS CHOSE TO HAVE OUTPATIENT SURGERY AT SAINT MARY'S, GENERATING $47 MILLION IN REVENUE.

OUTPATIENT SERVICES INCLUDE BUT ARE NOT LIMITED TO: MEDICAL IMAGING, BLOOD DRAW AND LAB SERVICES, CARDIAC AND PULMONARY REHABILITATION CLASSES, NUTRITIONAL COUNSELING AND EXPECTANT PARENT CLASSES. SAINT MARY'S SATELLITE FACILITIES INCLUDE HEALTH AND WELLNESS CENTERS PROVIDING URGENT CARE, BLOOD DRAW STATIONS AND X-RAY SERVICES IN NAUGATUCK AND WOLCOTT; OUTPATIENT REHABILITATION THERAPY OFFICES IN WATERBURY, WOLCOTT AND NAUGATUCK; OUTPATIENT SLEEP DISORDERS CENTERS IN WATERBURY AND WOLCOTT; THE BREAST & ONCOLOGY CENTERS IN SOUTHBURY AND PROSPECT, AND OCCUPATIONAL THERAPY IN WATERBURY.

SAINT MARY'S HAS BEEN RECOGNIZED AT THE STATE AND NATIONAL LEVELS AS A DISTINGUISHED PROVIDER OF OUTPATIENT SERVICES.

ONE ADDITION TO THE OUTPATIENT SERVICES INCLUDED THE LIONS LOW VISION CENTER WHICH IS ONE OF ONLY FIVE CENTERS IN CONNECTICUT AND THE ONLY CETNER OF ITS KIND IN GREATER WATERBURY. SPECIALISTS COLLABORATE WITH PATIENTS' EYE CARE PROFESSIONLS AND HELP PATIENTS MAKE THE MOST OF THEIR AVAILABLE VISION WITH EXERCISES, COMPENSATORY STRATEGIES, AND TRAINING WITH LOW VISION AIDES.

SAINT MARY'S IS AMONG THE LARGEST AND BUSIEST EMERGENCY DEPARTMENTS IN THE STATE OF CONNECTICUT. IN FACT, WITH APPROXIMATELY 67,000 EMERGENCY VISITS PER YEAR, WE RANK AS THE 9TH BUSIEST IN THE STATE.

THE SAINT MARY'S EMERGENCY DEPARTMENTS IS A CERTIFIED LEVEL 2 TRAUMA CENTER, AND ALL PHYSICIANS ARE BOARD CERTIFIED IN EMERGENCY MEDICINE. THE EMERGENCY DEPARTMENT PLAYS A CRITICAL ROLE IN HELPING SAINT MARY'S ACHIEVE ITS EXTRAORDINARY PERFORMANCE WITH DOOR-TO-BALLOON TIME, A MEASURE OF THE TIME IT TAKES A HEART ATTACK VICTIM TO HAVE HIS OR HER BLOCKED ARTERIES OPENED. SAINT MARY'S MEDIAN DOOR-TO-BALLOON TIME IS 60 MINUTES. SAINT MARY'S DOOR-TO-BALLOON TIME IS 30 MINUTES FASTER THAN NATIONAL GUIDELINES SET BY THE AMERICAN COLLEGE OF CARDIOLOGY FOR OPENING BLOCKED ARTERIES.

THE DEPARTMENT ALSO PROVIDES AMBULATORY CARE SERVICES, WHICH ARE DESIGNED TO ACCOMMODATE NON-EMERGENT, LOWER ACUITY NEEDS. THIS UNIT CONTAINS A PEDIATRIC CENTER, WHICH IS STAFFED BY PEDIATRICIANS EACH AFTERNOON.

FINALLY, THE EMERGENCY DEPARTMENT CONTAINS A DEDICATED BEHAVIORAL HEALTH AREA, SUPPORTED BY A PSYCHIATRIST, SOCIAL WORKER AND SPECIALIZED NURSES. THIS UNIT PROVIDES A MUCH NEEDED RESOURCE FOR SERVING OUR PATIENT POPULATION, AND HAS SEEN CONTINUED GROWTH AND INCREASE IN DEMAND.

SAINT MARY'S CANCER PROGRAM WAS AWARDED A THREE-YEAR ACCREDITATION FROM THE AMERICAN COLLEGE OF SURGEONS' COMMISSION ON CANCER WITH COMMENDATION.

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ONLY 40 PERCENT OF ALL U.S. HOSPITALS SURVEYED BY THE COMMISSION ACHIEVE THIS LEVEL OF RECOGNITION. ACS ACCREDITATION ENSURES THAT PATIENTS WHO CHOOSE SAINT MARY'S FOR CANCER CARE HAVE ACCESS TO A COMPLETE RANGE OF STATE-OF-THE-ART SERVICES AND EQUIPMENT, A TEAM THAT COORDINATES THE BEST AVAILABLE TREATMENT OPTIONS, AND ACCESS TO CLINICAL TRIALS AND NEW TREATMENT OPTIONS, AS WELL AS EARLY DETECTION PROGRAMS, EDUCATION AND SUPPORT SERVICES.

SAINT MARY'S WOUND HEALING CENTER IS STAFFED BY A SPECIALIZED TEAM OF PHYSICIANS, SURGEONS, NURSES AND TECHNICIANS, WHO COLLABORATE TO PRODUCE THE BEST POSSIBLE OUTCOMES. ON AVERAGE, 92.7 PERCENT OF PATIENTS WHO COME TO THE CENTER WITH CHRONIC WOUNDS THAT HAVE RESISTED TRADITIONAL TREATMENT ACHIEVE SUCCESSFUL RESULTS WITHIN 14 WEEKS. SPECIALIZED WOUND CARE ALSO HELPS PATIENTS WITH DIABETIC ULCERS, PRESSURE ULCERS, INFECTIONS AND COMPROMISED SKIN GRAFTS. IN ADDITION THE CENTER OFFERS HYPERBARIC OXYGEN THERAPY, WHICH IS PARTICULARLY EFFECTIVE FOR PATIENTS WHO SUFFER FROM RADIATION DAMAGE OR FACE THE POSSIBILITY OF AMPUTATION.

FORM 990, PART III
BUILDING UPON A LEGACY OF CARING THE MISSION OF SAINT MARY'S HOSPITAL IS TO PROVIDE EXCELLENT HEALTHCARE SERVICES IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

IT IS THE HOSPITAL'S VISION TO BECOME AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS CREATING EXCEPTIONAL VALUE FOR THOSE WE SERVE THROUGH TRUSTED PARTNERSHIPS THAT EMPOWER AND TRANSFORM LIVES. THE HOSPITAL'S STAFF,

MEDICAL STAFF, BOARD OF DIRECTORS, FOUNDATION, AUXILIARY, AND VOLUNTEERS ARE ALSO UNITED BY THESE VALUES:

-INTEGRITY - COMMITMENT TO DOING WHAT IS RIGHT

- CARING - COMPASSIONATE APPROACH TO ADDRESSING THE HEALTHCARE NEEDS OF ALL PEOPLE

- ACCOUNTABILITY - PERSONAL RESPONSIBILITY FOR THE PERFORMANCE OF SAINT MARY'S HEALTH SYSTEM

- RESPECT - RESPECT FOR THE DIGNITY, WORTH, AND RIGHTS OF OTHERS

- EXCELLENCE - WORKING TOGETHER IN PURSUIT OF SUPERIOR CLINICAL QUALITY AND SERVICE TO OTHERS

990 PART VI SECTION A LINE 7A

SAINT MARY'S HEALTH SYSTEM, INC. IS THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC. AND APPOINTS THE BOARD OF DIRECTORS.

ARE THE DECISIONS OF THE GOVERNING BODY SUBJECT TO APPROVAL

990 PART VI SECTION A LINE 7B

PURSUANT TO THE PROVISIONS OF SECTION 33-1080(B) OF THE CONNECTICUT REVISED NON-STOCK CORPORATION ACT AND THE AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE CORPORATION, THERE SHALL BE RESERVED TO THE ARCHBISHOP OF THE HARTFORD ROMAN CATHOLIC ARCHDIOCESE OF HARTFORD (UNLESS SPECIFICALLY DELEGATED BY HIM) THE FOLLOWING RIGHTS AND POWERS: (A)TO APPROVE THE MISSION OR PURPOSE AND THE PHILOSOPHY OF THE CORPORATION AND OF ANY SAINT MARY'S SUBSIDIARIES. (B)TO APPROVE THE ACQUISITION, ALIENATION OR CONVEYANCE OF THE REAL PROPERTY OF THE CORPORATION THAT IS VALUED AT AN AMOUNT GREATER THAN THAT ESTABLISHED BY

THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW OR TO PLACE A MORTGAGE ON SUCH PROPERTY OR TO BORROW FUNDS IN AMOUNTS GREATER THAN THOSE ESTABLISHED BY THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW, WHETHER IN A SINGLE TRANSACTION OR A SERIES OF RELATED TRANSACTIONS. (C)TO APPROVE THE DISPOSAL OF ALL OR SUBSTANTIALLY ALL OF THE PHYSICAL ASSETS OF THE CORPORATION AND TO APPROVE THE MERGER OR CONSOLIDATION OF THE CORPORATION. (D)TO APPROVE THE AMENDMENT OF THE CERTIFICATE OF INCORPORATION OR THE BYLAWS OF THE CORPORATION.

PART VI, SECTION B, LINE 11A

THE FORM 990 WAS DISTRIBUTED TO BOARD MEMBERS AND THE ORGANIZATION'S FINANCE COMMITEE FOR THEIR REVIEW PRIOR TO FILING TO ENSURE ACCURACY AND COMPLETENESS. A COMPLETE COPY OF THE ORGANIZATION'S FINAL FORM 990, INCLUDING ALL REQUIRED SCHEDULES, AS ULTIMATELY FILED WITH THE IRS, WAS PROVIDED TO EACH MEMBER OF THE BOARD BEFORE ITS FILING WITH THE IRS.

990 PART VI - SECTION B - LINE 12C

ANNUALLY, EACH DIRECTOR, OFFICER, AND BOARD COMMITTEE MEMBER OF SMHS AND ANY OF ITS AFFILIATES, AS APPROPRIATE, WILL SIGN A STATEMENT WHICH AFFIRMS THAT THE PERSON:

1) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY;

2) HAS READ AND UNDERSTANDS THE POLICY; AND

3) HAS AGREED TO COMPLY WITH THE POLICY.

THE STATEMENTS WILL BE DISTRIBUTED ANNUALLY BY THE COMPLIANCE OFFICER AND RETURNED TO THE CEO OR DELEGATED PERSON, WHERE THEY WILL BE RECORDED, REVIEWED, SUMMARIZED AND PRESENTED TO THE CHAIRPERSON OF THE BOARD, AS WELL AS TO THE AUDIT AND GOVERNANCE COMMITTEES, WHERE THEY EXISTS. CONFLICT OF INTEREST STATEMENTS WILL BE MAINTAINED FOR A MINIMUM OF SEVEN YEARS BY THE COMPLIANCE OFFICER.

CONFLICT OF INTEREST FORMS PROVIDED BY OFFICERS, DIRECTORS AND BOARD COMMITTEE MEMBERS WILL BE FORWARDED TO THE COMPLIANCE OFFICER, ALONG WITH A STATEMENT OF IMPACT AS TO THE EFFECT OF THE CONFLICT OF INTEREST ON THE BUSINESS AND ANY ACTION TAKEN TO MINIMIZE THE EFFECT. THEY WILL BE MAINTAINED BY THE COMPLIANCE OFFICER FOR A MINIMUM OF SEVEN YEARS.

990 PART VI - SECTION B - LINES 15A & 15B

THE PROCESS FOR DETERMINING THE COMPENSATION OF THE HOSPITAL'S TOP MANAGEMENT OFFICIALS, INCLUDING THE CEO, ALL OFFICERS, AND KEY EMPLOYEES, MEET THE THREE REQUIREMENTS OF THE REBUTTABLE PRESUMPTION. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY THE ORGANIZATION'S EXECUTIVE COMPENSATION COMMITTEE. THE COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS FOR THE PURPOSE OF ASSISTING THE BOARD TO FULFILL ITS RESPONSIBILY TO THE HOSPITAL AND THE COMMUNITY TO ENSURE THE COMPENSATION IS IN ACCORDANCE WITH THE HOSPITAL'S POLICIES. THE COMMITTEE IS COMPRISED OF SIX DIRECTORS WHO ARE INDEPENDENT OF MANAGEMENT AND THE HOSPITAL AND FREE OF ANY CONFLICTS OF INTEREST THAT WOULD INTERFERE WITH THEIR EXERCISE OF INDEPENDENT JUDGEMENT. PRIOR TO MAKING ANY COMPENSATION DECISIONS, THE EXECUTIVE COMPENSATION COMMITTEE OBTAINED AND

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Name of the organization: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

RELIED UPON APPROPRIATE DATA AS TO COMPARABILITY. THE COMMITTEE CONTRACTS AN INDEPENDENT COMPENSATION CONSULTANT AND UTILIZES LOCAL AND NATIONAL COMPENSATION SURVERY'S TO SET COMPENSATION LEVELS. FINALLY, THE EXECUTIVE COMPENSATION COMMITTEE ADEQUATELY AND TIMELY DOCUMENTED THE BASIS FOR SETTING COMPENSATION CONCURRENTLY WITH THE MAKING OF THE DETERMINATION.

PART VI, SECTION C, QUESTION 19

COPIES OF THE GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

PART XI, LINE 9

TRANSFERS TO AFFILIATES	($14,778,000)
MINIMUM PENSIONS LIAB CHANGE	($13,377,000)
CHANGE IN FOUNDATION INTEREST	$ 351,580
NET ADDITIONS TO ASSETS HELD IN TRUST	$ 426,000
OTHER	($ 47,173)
TOTAL	($27,424,593)

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
SODEXHO INC. & AFFILIATES PO BOX 905374 CHARLOTTE, NC 28290	HOSPITAL MGMT SVCS	3,285,079.

Public Disclosure Copy

Name of the organization: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

ATTACHMENT 1 (CONT'D)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MIDDLE CT EMERGENCY PHYSICIANS 1000 RIVER ROAD, SUITE 100 CONSHOHOCKEN, PA 19428	EMERGENCY ROOM SVCS	2,825,989.
PRECYSE SOLUTIONS LLC PO BOX 11407 BIRMINGHAM, AL 35246	CONTRACT LABOR SVCS	3,886,995.
FINANCIAL HEALTH STRATEGIES 704 QUINCE ROAD, SUITE 300 GAITHERSBURG, MD 20878	CONTRACT LABOR SVCS	1,449,472.
ANTHELIO ONE FINANCIAL CENTER BOSTON, MA 02111	HOSP MGMT/IT HOSTING	2,599,856.

ATTACHMENT 2

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
MRI PARTNERSHIP INCOME	-55,484.			-55,484.
DIAGNOSTIC IMAGING CENTER INCOME	646,709.			646,709.
PREMIER INCOME	667,720.		-4,499.	672,219.
HLRCC JV NET INCOME	-423,587.			-423,587.
DIVIDEND & INTEREST REVENUE	2,931,875.			2,931,875.
TOTALS	3,767,233.		-4,499.	3,771,732.

ATTACHMENT 3

Public Disclosure Copy

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

ATTACHMENT 3 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION		BEGINNING BOOK VALUE	ENDING BOOK VALUE	COST OR FMV
MARKETABLE SECURITIES		18,505,914.	20,802,742.	FMV
	TOTALS	18,505,914.	20,802,742.	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990. ▶ See separate instructions.

▶ Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

ST. MARY'S HOSPITAL, INC.

Employer identification number

06-0646844

Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ST. MARY'S INDEMNITY COMPANY, LLC 06-0646844 126 COLLEGE STREET BURLINGTON, VT 05401	INSURANCE	VT	2,523,000.	46,719,000.	ST MARY HOSP
(2) ST. MARY'S PHYSICIAN PARTNERS, LLC 46-5760769 56 FRANKLIN STREET WATERBURY, CT 06706	ACCOUNT. CARE	CT	0	0	ST MARY HOSP
(3)					
(4)					
(5)					
(6)					

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1) ST. MARY'S HEALTH SYSTEM, INC. 22-2528399 56 FRANKLIN STREET WATERBURY, CT 06703	HOLDING CO.	CT	501(C)(3)	11B	N/A		X
(2) SAINT MARY'S FOUNDATION 22-2528400 56 FRANKLIN STREET WATERBURY, CT 06703	FUNDRAISING	CT	501(C)(3)	7	ST MARY HOSP	X	
(3) HAROLD LEEVER REGIONAL CANCER CENTER 06-1548409 1075 CHASE PARKWAY WATERBURY, CT 06708	TREATMENT CTR	CT	501(C)(3)	3	ST MARY HOSP	X	
(4) HEART CENTER OF GREATER WATERBURY, INC. 83-0416893 P.O. BOX 2153 WATERBURY, CT 06722	MANAGEMENT	CT	501(C)(3)	11A	ST MARY HOSP	X	
(5)							
(6)							
(7)							

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) DIAGNOSTIC IMAGING OF SOUTHBUR 385 MAIN STREET SOUTH	IMAGING CENTER	CT	N/A	RELATED	735,013.	1,412,020.		X	0			60.0000
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) FRANKLIN MEDICAL GROUP, PC 06-1470493 56 FRANKLIN STREET WATERBURY, CT 06706	PHYSICIAN OFF	CT	N/A	C CORP	-12,810,000.	5,492,000.	100.0000	X	
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

		Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a X	
b	Gift, grant, or capital contribution to related organization(s)	1b X	
c	Gift, grant, or capital contribution from related organization(s)	1c X	
d	Loans or loan guarantees to or for related organization(s)	1d	X
e	Loans or loan guarantees by related organization(s)	1e	X
f	Dividends from related organization(s)	1f	X
g	Sale of assets to related organization(s)	1g	X
h	Purchase of assets from related organization(s)	1h	X
i	Exchange of assets with related organization(s)	1i	X
j	Lease of facilities, equipment, or other assets to related organization(s)	1j	X
k	Lease of facilities, equipment, or other assets from related organization(s)	1k	X
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l X	
m	Performance of services or membership or fundraising solicitations by related organization(s)	1m X	
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n X	
o	Sharing of paid employees with related organization(s)	1o X	
p	Reimbursement paid to related organization(s) for expenses	1p	X
q	Reimbursement paid by related organization(s) for expenses	1q X	
r	Other transfer of cash or property to related organization(s)	1r	X
s	Other transfer of cash or property from related organization(s)	1s X	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	FRANKLIN MEDICAL GROUP, PC	B	14,281,747.	FMV
(2)	FRANKLIN MEDICAL GROUP, PC	M	2,961,355.	FMV
(3)	DIAGNOSTIC IMAGING OF SOUTHBURY, LLC	S	546,000.	FMV
(4)	ST. MARY'S HOSPITAL FOUNDATION, INC.	C	75,420.	FMV
(5)	FRANKLIN MEDICAL GROUP, PC	O	495,431.	FMV
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

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Part VII **Supplemental Information**
Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

KPMG

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

December 22, 2014

SAINT MARY'S HOSPITAL, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

Assets		2014	2013
Current assets:			
Cash and cash equivalents	$	25,797	28,902
Short-term investments		17	29
Current portion of assets whose use is limited		5,948	8,039
Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013		30,196	30,730
Other current assets		6,612	4,357
Total current assets		68,570	72,057
Marketable securities		20,803	18,506
Assets whose use is limited:			
By donor and held in trust by others		15,696	15,258
For estimated self-insurance liability		41,038	31,394
By bond indenture		4,321	4,324
Net interest in Foundation		5,182	4,874
Other		6	6
Total assets whose use is limited		66,243	55,856
Less current portion of assets whose use is limited		5,948	8,039
Noncurrent assets whose use is limited		60,295	47,817
Property and equipment, net		62,371	63,874
Other assets:			
Investments in joint venture arrangements		10,024	10,697
Deferred financing costs, net		103	128
Total other assets		10,127	10,825
Total assets	$	222,166	213,079
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term obligations	$	2,509	2,490
Accounts payable		17,252	20,899
Salaries, wages, and payroll withholdings		5,643	4,734
Due to third-party payors, net		783	6,035
Accrued expenses and other current liabilities		14,308	16,486
Total current liabilities		40,495	50,644
Long-term liabilities:			
Long-term obligations, net of current portion		17,891	20,374
Estimated self-insurance liability		31,814	21,908
Pension and deferred compensation		72,182	58,823
Other long-term liabilities		9,523	10,172
Total long-term liabilities		131,410	111,277
Net assets:			
Unrestricted Hospital		30,795	32,332
Noncontrolling interest in subsidiaries		370	302
Total unrestricted		31,165	32,634
Temporarily restricted		2,415	2,269
Permanently restricted		16,681	16,255
Total net assets		50,261	51,158
Total liabilities and net assets	$	222,166	213,079

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Revenue from patient services, net of contractual allowances	$ 279,161	268,899
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	268,087	256,021
Other operating revenues	9,776	6,871
Total revenues	277,863	262,892
Expenses:		
Salaries and wages	113,207	108,642
Employee benefits	28,620	31,294
Supplies and other expenses	115,262	103,072
Depreciation and amortization	10,455	9,977
Interest	1,438	1,594
Total expenses	268,982	254,579
Operating income	8,881	8,313
Nonoperating gains (losses):		
Investment income, net	3,824	2,390
Equity in earnings of joint ventures	189	1,170
Change in net assets of Foundation	281	437
Net loss on disposal of assets	(46)	(230)
Other	(283)	(1,572)
Total nonoperating gains, net	3,965	2,195
Excess revenues over expenses	12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	$ (1,469)	31,754

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 12,846	10,508
Net assets released from restriction for capital expenditures	(48)	545
Capital transactions with affiliates	(363)	(519)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	401
Change in accumulated pension charges to unrestricted net assets	(13,377)	20,819
(Decrease) increase in unrestricted net assets	(1,469)	31,754
Temporarily restricted net assets:		
Change in net assets of Foundation	146	(100)
Change in net assets of Cancer Center, including releases for capital expenditures	—	(177)
Increase (decrease) in temporarily restricted net assets	146	(277)
Permanently restricted net assets:		
Net earnings on assets held in trust by others	1,177	1,653
Appropriation for expenditure	(751)	(704)
Increase in permanently restricted net assets	426	949
(Decrease) increase in net assets	(897)	32,426
Net assets – beginning of year	51,158	18,732
Net assets – end of year	$ 50,261	51,158

See accompanying notes to consolidated financial statements.

SAINT MARY'S HOSPITAL, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (897)	32,426
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,480	10,003
Net loss on disposal of assets	46	230
Change in unrealized losses (gains) on investments	527	(401)
Change in net interest in Foundation	(308)	(379)
Change in net assets of Cancer Center	—	177
Change in accumulated pension charges to unrestricted net assets	13,377	(20,819)
Change in permanently restricted net assets	(426)	(949)
Investment income, net	(3,824)	(2,390)
Equity in earnings of joint ventures	(189)	(1,170)
(Increase) decrease in operating assets:		
Accounts receivable, net	534	3,287
Other current assets	(2,255)	125
Increase (decrease) in operating liabilities:		
Due to third-party payors, net	(5,252)	(972)
Accounts payable and other current liabilities	(6,702)	1,522
Estimated self-insurance liability	9,906	2,846
Pension, deferred compensation, and other long-term liabilities	(667)	526
Net cash provided by operating activities	14,350	24,062
Cash flows from investing activities:		
Purchases of property and equipment	(7,212)	(15,479)
Distributions from joint ventures	546	420
Investments in joint venture arrangements	316	272
Change in other assets whose use is limited	(6,258)	106
Change in assets held in trust by others	426	949
Net decrease in investments	(2,812)	(2,052)
Net cash used in investing activities	(14,994)	(15,784)
Cash flows from financing activities:		
Change in assets whose use is limited by bond indenture	3	(224)
Payments on long-term obligations	(2,464)	(1,676)
Net cash used in financing activities	(2,461)	(1,900)
Net (decrease) increase in cash and cash equivalents	(3,105)	6,378
Cash and cash equivalents – beginning of year	28,902	22,524
Cash and cash equivalents – end of year	$ 25,797	28,902
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,402	1,558
Supplemental disclosure of noncash item:		
Assets acquired under capital lease	$ —	600

See accompanying notes to consolidated financial statements.

(1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

(2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

(a) Charity and Uncompensated Care

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

(b) Education, Research and Training

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

(c) Wellness and Health Promotional Activities

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

(d) Leadership, Advocacy and Voluntarism

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

(e) Dollar, Time and In-kind Donations

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

(Continued)

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

(f) Other Support Services

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

(b) Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

(c) Charity Care and Provision for Uncollectible Accounts

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

(e) Assets Whose Use is Limited

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

(f) Marketable Securities

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

(h) Investments in Joint Venture Arrangements

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

(i) Fair Value of Financial Instruments

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

(j) Net Interest in Foundation

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

(k) Net Asset Categories

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

Temporarily Restricted – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

(l) Excess of Revenues over Expenses

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

(m) Income Taxes

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

(n) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

(o) Professional and General Liability

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

(p) Recently Issued Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

(q) Prior Year Reclassifications

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

(4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

	2014	2013
Gross revenue from patient services	$ 733,919	670,163
Contractual and other allowances	(454,430)	(401,170)
Charity care	(328)	(94)
Provision for uncollectible accounts, net of recoveries	(11,074)	(12,878)
Net revenue from patient services	$ 268,087	256,021

(Continued)

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Governmental and other third-party payors	Self-pay	Total all payors
Revenue from patient services, net of contractual allowances, as of September 30, 2014	$ 271,936	7,225	279,161
Revenue from patient services, net of contractual allowances, as of September 30, 2013	$ 257,527	11,372	268,899

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

	2014	2013
Medicare (including Medicare managed care)	31.6%	31.9%
Medicaid	12.3	13.1
Other third-party payors	32.5	33.1
Private pay patients	23.6	21.9
	100.0%	100.0%

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

(5) Regulatory and Legislative Matters

(a) State of Connecticut Regulatory Environment

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

(b) Federal Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse and security and privacy of health information. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

	2014					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 18,630	18,630	—	—	—	—
Corporate bonds	11,820	11,807	1,062	(18)	4,559	(162)
U.S. government and agency obligations	14,023	13,990	2,926	(16)	1,686	(34)
Mutual funds	25,357	21,016	608	(9)	—	—
Equities	1,145	1,173	605	(62)	—	—
	$ 70,975	66,616	5,201	(105)	6,245	(196)

	2013					
	Total		Less than 12 months		12 months or more	
	Fair value	Cost	Fair value	Unrealized losses	Fair value	Unrealized losses
Cash and cash equivalents	$ 2,671	2,671	—	—	—	—
Corporate bonds	15,083	15,885	4,668	(274)	734	(53)
U.S. government and agency obligations	13,769	12,984	3,731	(42)	304	(5)
Mutual funds	27,155	21,326	706	(16)	—	—
Equities	4,633	4,052	—	—	—	—
	$ 63,311	56,918	9,105	(332)	1,038	(58)

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 17,838	—	—	17,838
Domestic corporate bonds	—	9,838	—	9,838
U.S. government and agency obligations	—	12,347	—	12,347
Equity mutual funds	14,925	—	—	14,925
Equity funds	331	—	—	331
Total	33,094	22,185	—	55,279
Assets held in trust by others: Perpetual trust	—	—	15,696	15,696
Total	$ 33,094	22,185	15,696	70,975

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,307	—	—	2,307
Domestic corporate bonds	—	12,723	—	12,723
U.S. government and agency obligations	—	11,518	—	11,518
Equity mutual funds	17,017	—	—	17,017
Equity funds	4,488	—	—	4,488
Total	23,812	24,241	—	48,053
Assets held in trust by others: Perpetual trust	—	—	15,258	15,258
Total	$ 23,812	24,241	15,258	63,311

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

	2014	2013
Perpetual trust:		
Fair value at beginning of the year	$ 15,258	14,299
Net realized and change in unrealized gains	1,177	1,653
Appropriation of endowment assets for expenditure	(739)	(694)
Fair value at end of the year	$ 15,696	15,258

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(Continued)

(7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

	2014	2013
Land and land improvements (5–25 yrs)	$ 7,911	7,328
Buildings and building improvements (10–40 yrs)	67,094	67,017
Equipment (3–25 yrs)	122,662	114,099
Projects in process	395	1,217
	198,062	189,661
Less accumulated depreciation and amortization	(135,691)	(125,787)
Property and equipment, net	$ 62,371	63,874

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

(8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments	$ 19,625	21,475
Capital leases	891	1,531
	20,516	23,006
Less unamortized portion of bond discount	(116)	(142)
Less current portion	(2,509)	(2,490)
	$ 17,891	20,374

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

	Long-term obligations	Capital leases
Year ending September 30:		
2015	$ 1,960	549
2016	2,090	248
2017	2,215	94
2018	2,360	—
2019	2,510	—
Thereafter	8,490	—
	$ 19,625	891
Interest payments		153
		$ 1,044

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

(9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

(10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 32,634	32,332	302
Excess (deficiency) of revenues over expenses	12,846	12,414	432
Net assets released from restriction for capital expenditures	(48)	(48)	—
Transfers to affiliates	(363)	1	(364)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	(527)	—
Change in accumulated pension charges to unrestricted net assets	(13,377)	(13,377)	—
Unrestricted net assets, end of year	$ 31,165	30,795	370

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

	Total	Controlling interest	Noncontrolling interest
Unrestricted net assets, beginning of year	$ 880	528	352
Excess (deficiency) of revenues over expenses	10,508	10,153	355
Net assets released from restriction for capital expenditures	545	545	—
Transfers to affiliates	(519)	(114)	(405)
Change in unrealized gains on marketable securities and other assets whose use is limited	401	401	—
Change in accumulated pension charges to unrestricted net assets	20,819	20,819	—
Unrestricted net assets, end of year	$ 32,634	32,332	302

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

	2014	2013
Cancer	$ 212	196
Building and equipment	421	428
Community services	511	518
Education	186	153
Other	1,085	974
	$ 2,415	2,269

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

	2014	2013
Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations	$ 15,713	15,287
Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support:		
Hospital operations	818	818
Medical education	150	150
	$ 16,681	16,255

(11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by the Act.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

		Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds at September 30, 2014	$	457	16,681	17,138
Donor-restricted endowment funds at September 30, 2013	$	375	16,255	16,630

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

		Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	$	375	16,255	16,630
Investment return:				
Investment income		110	913	1,023
Net (depreciation) appreciation		(23)	264	241
Total investment return		87	1,177	1,264
Appropriation of endowment assets for expenditure		(5)	(751)	(756)
Endowment net assets, September 30, 2014	$	457	16,681	17,138

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2012	$ 261	15,306	15,567
Investment return:			
Investment income	96	789	885
Net appreciation	19	864	883
Total investment return	115	1,653	1,768
Appropriation of endowment assets for expenditure	(1)	(704)	(705)
Endowment net assets, September 30, 2013	$ 375	16,255	16,630

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

(12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

		2014	2013
Reserves for premiums held on deposit at beginning of year	$	10,544	6,657
Current period payments from loss escrow		4,600	2,450
Change in reserve for premiums held on deposit for loss portfolio transfer		374	6,673
Current period payments from reserves for premiums held on deposit		403	5,236
Reserves for premiums held on deposit at end of year	$	15,115	10,544

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

	2014	2013
Balance at beginning of period	$ 14,993	14,750
Less reinsurance recoverable	(2,650)	(2,300)
Net balance at beginning of period	12,343	12,450
Incurred related to:		
Current year	4,547	4,493
Prior years	(993)	(4,034)
Total incurred	3,554	459
Paid related to:		
Current year	73	3
Prior years	350	563
Total paid	423	566
Net balance at end of period	15,474	12,343
Add reinsurance recoverable	2,750	2,650
Balance at end of period	$ 18,224	14,993

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

(13) Retirement Plans

(a) Defined Benefit Plan

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

		2014	2013
Change in benefit obligation:			
Benefit obligation, beginning of year	$	124,196	138,482
Interest cost		6,064	5,613
Actuarial loss (gain)		17,454	(13,726)
Benefits paid		(6,786)	(6,173)
Benefit obligation, end of year		140,928	124,196
Change in plan assets:			
Fair value of plan assets, beginning of year		66,215	59,683
Actual return on plan assets		6,091	7,340
Contributions		4,121	5,365
Benefits paid		(6,786)	(6,173)
Fair value of plan assets, end of year		69,641	66,215
Funded status at year end	$	(71,287)	(57,981)
Amounts recognized in consolidated balance sheets consist of:			
Noncurrent liabilities	$	(71,287)	(57,981)
Accumulated charges to unrestricted net assets, consisting of net actuarial losses		56,338	42,961
Net amount recognized	$	(14,949)	(15,020)

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

	2014	2013
Components of net periodic benefit cost:		
Interest cost	$ 6,064	5,613
Expected return on plan assets	(5,064)	(4,724)
Net amortization and deferral	3,050	4,477
Net periodic benefit cost	4,050	5,366
Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands):		
Net (loss) gain	(10,327)	25,296
Net amortization and deferral	(3,050)	(4,477)
(Decrease) increase recognized in changes to unrestricted net assets	(13,377)	20,819
(Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge	$ (17,427)	15,453

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

	2014	2013
Weighted average assumptions at September 30:		
Discount rate for benefit obligations	4.55%	5.02%
Discount rate for net periodic benefit cost	5.02	4.15
Expected return on plan assets	8.00	8.00

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 2,241	—	—	2,241
Domestic corporate bonds	—	12,827	—	12,827
U.S. government and agency obligations	—	261	—	261
Equity mutual funds	47,991	—	—	47,991
Fixed income mutual funds	6,321	—	—	6,321
Preferred equity securities	—	—	—	—
Total	$ 56,553	13,088	—	69,641

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

	Level 1	Level 2	Level 3	Total
Money market funds	$ 1,745	—	—	1,745
Domestic corporate bonds	—	14,443	—	14,443
U.S. government and agency obligations	—	291	—	291
Equity mutual funds	44,545	—	—	44,545
Fixed income mutual funds	4,747	—	—	4,747
Preferred equity securities	—	444	—	444
Total	$ 51,037	15,178	—	66,215

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

The following benefit payments are expected to be paid (in thousands):

2015	$	7,408
2016		7,574
2017		7,848
2018		8,196
2019		8,422
2020 through 2024		45,151
	$	84,599

(b) Defined Contribution Plan

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

(c) Supplemental Pension Plan

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

(14) Leases and Rental Expenses

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

Fiscal year:		
2015	$	3,208
2016		2,429
2017		1,654
2018		1,349
2019		1,186
2020 and thereafter		5,253
	$	15,079

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

(15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

(16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

(17) Investments in Joint Venture Arrangements

Naugatuck Valley MRI Limited Partnership

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

(18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Investment income related to short-term investments and investments for self-insurance	$ 280	276
Cafeteria	1,170	1,173
Outside services	545	274
State grants	656	742
Parking fees	232	320
Day care	718	665
Rentals	1,242	1,263
Meaningful use	2,962	1,149
Other	1,971	1,009
Total	$ 9,776	6,871

(19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

	2014	2013
Health care services	$ 225,237	215,207
General and administrative	43,745	39,372
	$ 268,982	254,579

(20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

(21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current assets:						
Cash and cash equivalents	$ 24,610	823	—	364	—	25,797
Short-term investments	17	—	—	—	—	17
Current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Accounts receivable, net	26,816	2,999	(68)	381	68	30,196
Other current assets	6,108	253	5,749	17	(5,515)	6,612
Total current assets	58,696	4,075	10,484	762	(5,447)	68,570
Marketable securities	20,803	—	—	—	—	20,803
Assets whose use is limited:						
By donor and held in trust by others	15,696	—	—	—	—	15,696
For estimated self-insurance liability	—	—	41,038	—	—	41,038
By bond indenture	4,321	—	—	—	—	4,321
Net interest in Foundation	5,182	—	—	—	—	5,182
Other	6	—	—	—	—	6
Total assets whose use is limited	25,205	—	41,038	—	—	66,243
Less current portion of assets whose use is limited	1,145	—	4,803	—	—	5,948
Noncurrent assets whose use is limited	24,060	—	36,235	—	—	60,295
Property and equipment, net	59,768	1,417	—	1,186	—	62,371
Other assets:						
Investments in joint venture arrangements	23,723	—	—	—	(13,699)	10,024
Deferred financing costs, net	103	—	—	—	—	103
Total other assets	23,826	—	—	—	(13,699)	10,127
Total assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

(Continued)

Exhibit 1

SAINT MARY'S HOSPITAL, INC.

Consolidating Balance Sheet

September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Current liabilities:						
Current portion of long-term obligations	$ 2,101	—	—	408	—	2,509
Accounts payable	16,795	432	—	25	—	17,252
Salaries, wages, and payroll withholdings	3,974	1,370	—	299	—	5,643
Due to third-party payors, net	783	—	—	—	—	783
Accrued expenses and other current liabilities	13,994	504	5,038	219	(5,447)	14,308
Total current liabilities	37,647	2,306	5,038	951	(5,447)	40,495
Long-term liabilities:						
Long-term obligations, net of current portion	17,818	—	—	73	—	17,891
Estimated self-insurance liability	3,278	—	28,536	—	—	31,814
Pension and deferred compensation	72,182	—	—	—	—	72,182
Other long-term liabilities	9,464	59	—	—	—	9,523
Total long-term liabilities	102,742	59	28,536	73	—	131,410
Net assets (deficit):						
Unrestricted	27,668	3,127	13,145	924	(14,069)	30,795
Noncontrolling interest in subsidiaries	—	—	—	—	370	370
Total unrestricted	27,668	3,127	13,145	924	(13,699)	31,165
Temporarily restricted	2,415	—	—	—	—	2,415
Permanently restricted	16,681	—	—	—	—	16,681
Total net assets	46,764	3,127	13,145	924	(13,699)	50,261
Total liabilities and net assets	$ 187,153	5,492	46,719	1,948	(19,146)	222,166

See accompanying independent auditors' report.

Exhibit 2

SAINT MARY'S HOSPITAL, INC.

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

	Saint Mary's Hospital	Franklin Medical Group, P.C.	Saint Mary's Indemnity Company, LLC	Southbury Diagnostic Diagnostic Imaging Center, Inc.	Eliminations	2014 Consolidated
Revenues:						
Revenue from patient services, net of contractual allowances	$ 248,807	24,157	—	6,197	—	279,161
Provision for uncollectible accounts	(10,078)	(996)	—	—	—	(11,074)
Net revenue from patient services	238,729	23,161	—	6,197	—	268,087
Other operating revenues	8,706	4,039	5,070	16	(8,055)	9,776
Total revenues	247,435	27,200	5,070	6,213	(8,055)	277,863
Expenses:						
Salaries and wages	85,350	26,689	—	1,168	—	113,207
Employee benefits	24,562	3,778	—	280	—	28,620
Supplies and other expenses	106,022	9,260	4,092	3,370	(7,482)	115,262
Depreciation and amortization	9,888	283	—	284	—	10,455
Interest	1,405	—	—	33	—	1,438
Total expenses	227,227	40,010	4,092	5,135	(7,482)	268,982
Operating income (loss)	20,208	(12,810)	978	1,078	(573)	8,881
Nonoperating gains (losses):						
Investment income, net	2,279	—	1,545	—	—	3,824
Equity in earnings of joint ventures	3,359	—	—	—	(3,170)	189
Change in net assets of Foundation	281	—	—	—	—	281
Net loss on disposal of assets	(46)	—	—	—	—	(46)
Other	(856)	—	—	—	573	(283)
Total nonoperating gains (losses), net	5,017	—	1,545	—	(2,597)	3,965
Excess (deficiency) of revenues over expenses	25,225	(12,810)	2,523	1,078	(3,170)	12,846
Net assets released from restriction	(48)	—	—	—	—	(48)
Capital transactions, net	(14,778)	14,778	—	(910)	547	(363)
Change in unrealized (losses) gains on marketable securities and other assets whose use is limited	(527)	—	(486)	—	486	(527)
Change in accumulated pension charges to unrestricted net assets	(13,377)	—	—	—	—	(13,377)
(Decrease) increase in unrestricted net assets	$ (3,505)	1,968	2,037	168	(2,137)	(1,469)

See accompanying independent auditors' report.

Saint Mary's HOSPITAL

DAILY CENSUS & REVENUE REPORT

August 21, 2015

UNIT	DEPT	STAFFED BEDS	DAILY BUDGET Patient Days	DAILY ACTUAL Patient Days	DAILY ACTUAL Discharges	MTD BUDGET Patient Days	MTD ACTUAL Patient Days	MTD VAR Patient Days	MTD BUDGET Discharges	MTD ACTUAL Discharges	MTD VAR Discharges	MTD BUDGET Length of Stay	MTD ACTUAL Length of Stay	MTD VAR Length of Stay
Medical Acute SH5	3130	21	19	16	10	404	365	-10%	96	108	12%	4.20	3.38	20%
Behave Hlth Srvc OB1	3570	12	11	12	2	233	243	4%	45	43	-4%	5.21	5.65	-8%
Telemetry	3140	20	18	19	4	375	311	-17%	81	74	-8%	4.65	4.20	10%
OB-4 Ortho/Neuro	3150	30	22	25	5	457	324	-29%	113	88	-22%	4.04	3.68	9%
X-3 Medical Oncology	3320	26	23	-	-	489	329	-33%	96	89	-7%	5.08	3.70	27%
OB-7 General Surgery	3200	23	18	16	8	381	264	-31%	129	84	-35%	2.96	3.14	-6%
Critical Care Unit	3500	16	11	9	1	231	200	-13%	20	15	-24%	11.76	13.33	-13%
Cardiovascular Unit	3510	8	4	4	-	75	74	-2%	26	9	-65%	2.92	8.22	-182%
Labor/Delivery	4070	23	8	12	2	175	183	5%	64	71	10%	2.72	2.58	5%
Holding		-	4	9	1	92	76	-18%	8	3	-63%	11.33	25.33	-124%
OB/Gyn	3600	-	0	-	-	6	3	-51%	-	2	#DIV/0!		1.50	#VALUE!
SubTotal		**179**	**139**	**122**	**33**	**2,919**	**2,372**	**-19%**	**677**	**586**	**-13%**	**4.31**	**4.05**	**6%**
Neonatal ICU (Critical Care Nurs)	3750	9	4	3	-	76	74	-2%	8	9	11%	9.33	8.22	12%
Nursery	3700	23	6	11	2	134	148	10%	47	62	33%	2.87	2.39	17%
Birthing Center	4310	2	0	-	-	1	-	-100%	1	-	-100%	2.00		#VALUE!
SubTotal		**34**	**10**	**14**	**2**	**211**	**222**	**5%**	**56**	**71**	**28%**	**3.80**	**3.13**	**18%**
TOTAL (excl Psych and Nursery)		**178**	**132**	**113**	**31**	**2,763**	**2,203**	**-20%**	**642**	**552**	**-14%**	**4.31**	**3.99**	**7%**
GRAND TOTAL (incl Psych & Nursery)		**213**	**149**	**136**	**35**	**3,130**	**2,594**	**-17%**	**733**	**657**	**-10%**	**4.27**	**3.95**	**8%**

Adult & Peds Occupancy	78%	68%	78%	63%
NICU Occupancy	40%	33%	40%	39%
Nursery Occupancy	28%	48%	28%	31%
Total Occupancy	70%	64%	70%	58%

	DAILY BUDGET	DAILY ACTUAL	MTD BUDGET	MTD ACTUAL	MTD VAR
Observation	6	6	134	173	29%
OP Surgery	61	54	923	854	-7%
Outpatient/Ref Lab	481	452	7,628	7,539	-1%
Psych OP	5	1	75	41	-45%
Series/Recurring	22	19	342	747	118%
Urgent Care	73	59	1,396	1,206	-14%
O/P Visits (excl ER Visits)	**648**	**591**	**10,498**	**10,580**	**1%**
ER Visits (only includes discharges)	178	173	3,735	3,678	-2%
Total O/P Visits (incl ER Visits)	**826**	**764**	**14,233**	**14,258**	**0%**

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

CHARGE TOTALS:	Daily Budget	Daily Actual	Daily Proj Excess / Shortfall	MTD Budget	MTD Actual	MTD Proj Excess / Shortfall	YTD Budget	271400155.2	YTD Proj Excess / Shortfall
IP Actual	845,681	849,771	$4,090	17,759,299	15,514,430	($2,244,869)	268,562,483	275,230,061	$6,667,578
OP Actual	1,581,240	1,265,268	($315,972)	25,567,827	24,489,757	($1,078,070)	378,303,382	380,918,026	$2,614,644
Total	**$2,426,921**	**$2,115,039**	**($311,882)**	**$43,327,126**	**$40,004,186**	**($3,322,940)**	**$646,865,865**	**$656,148,086**	**$9,282,221**
Budget variance	**-12.9%**			**-7.7%**			**1.4%**		

	7/31/2015	8/21/2015	Change
IP Accounts Receivable	23,037,971	20,577,457	(2,460,514)
OP Accounts Receivable	28,730,929	34,881,657	6,150,728
ACCOUNTS RECEIVABLE:	**$51,768,900**	**$55,459,114**	**3,690,214**
IP Unbilled Receivable	7,098,463	9,088,554	1,990,091
OP Unbilled Receivable	16,718,641	14,714,253	(2,004,388)
UNBILLED RECEIVABLE:	**23,817,104**	**23,802,807**	**($14,297)**
	$75,586,004	**$79,261,921**	**$3,675,917**

Saint Mary's HOSPITAL

DAILY CENSUS & REVENUE REPORT

August 22, 2015

UNIT	DEPT	STAFFED BEDS	DAILY BUDGET Patient Days	DAILY ACTUAL Patient Days	DAILY ACTUAL Discharges	MTD BUDGET Patient Days	MTD ACTUAL Patient Days	MTD VAR Patient Days	MTD BUDGET Discharges	MTD ACTUAL Discharges	MTD VAR Discharges	MTD BUDGET Length of Stay	MTD ACTUAL Length of Stay	MTD VAR Length of Stay
Medical Acute SH5	3130	21	19	15	8	424	380	-10%	101	116	15%	4.20	3.28	22%
Behave Hlth Srvc OB1	3570	12	11	12	-	244	255	4%	47	43	-8%	5.21	5.93	-14%
Telemetry	3140	20	18	18	4	392	329	-16%	84	78	-8%	4.65	4.22	9%
OB-4 Ortho/Neuro	3150	30	22	24	9	479	348	-27%	119	97	-18%	4.04	3.59	11%
X-3 Medical Oncology	3320	26	23	-	-	512	329	-36%	101	89	-12%	5.08	3.70	27%
OB-7 General Surgery	3200	23	18	18	4	400	282	-29%	135	88	-35%	2.96	3.20	-8%
Critical Care Unit	3500	16	11	10	1	242	210	-13%	21	16	-22%	11.76	13.13	-12%
Cardiovascular Unit	3510	8	4	4	-	79	78	-1%	27	9	-67%	2.92	8.67	-197%
Labor/Delivery	4070	23	8	7	6	183	190	4%	67	77	14%	2.72	2.47	9%
Holding		-	4	4	1	97	80	-17%	9	4	-53%	11.33	20.00	-77%
OB/Gyn	3600	-	0	-	-	6	3	-53%	-	2	#DIV/0!		1.50	#VALUE!
SubTotal		179	139	112	33	3,058	2,484	-19%	710	619	-13%	4.31	4.01	7%
Neonatal ICU (Critical Care Nurs)	3750	9	4	3	-	79	77	-3%	9	9	6%	9.33	8.56	8%
Nursery	3700	23	6	7	5	141	155	10%	49	67	37%	2.87	2.31	20%
Birthing Center	4310	2	0	-	-	1	-	-100%	1	-	-100%	2.00		#VALUE!
SubTotal		34	10	10	5	221	232	5%	58	76	31%	3.80	3.05	20%
TOTAL (excl Psych and Nursery)		178	132	103	33	2,895	2,306	-20%	672	585	-13%	4.31	3.94	9%
GRAND TOTAL (incl Psych & Nursery)		213	149	122	38	3,279	2,716	-17%	768	695	-9%	4.27	3.91	8%

Adult & Peds Occupancy	78%	63%	78%	63%	
NICU Occupancy	40%	33%	40%	39%	
Nursery Occupancy	28%	30%	28%	31%	
Total Occupancy	70%	57%	70%	58%	

	DAILY BUDGET	DAILY ACTUAL	MTD BUDGET	MTD ACTUAL	MTD VAR
Observation	6	7	140	180	29%
OP Surgery	-	2	923	856	-7%
Outpatient/Ref Lab	110	107	7,738	7,666	-1%
Psych OP	-	-	75	41	-45%
Series/Recurring	-	2	342	749	119%
Urgent Care	50	61	1,446	1,267	-12%
O/P Visits (excl ER Visits)	166	179	10,664	10,759	1%
ER Visits (only includes discharges)	178	164	3,913	3,842	-2%
Total O/P Visits (incl ER Visits)	344	343	14,577	14,601	0%

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

CHARGE TOTALS:		Daily Budget	Daily Actual	Daily Proj Excess / Shortfall	MTD Budget	MTD Actual	MTD Proj Excess / Shortfall	YTD Budget	271400155.2	YTD Proj Excess / Shortfall
IP Actual		845,681	509,906	($335,775)	18,604,980	16,024,335	($2,580,645)	269,408,164	275,739,966	$6,331,803
OP Actual		308,205	400,631	$92,426	25,876,032	24,890,388	($985,644)	378,611,587	381,318,657	$2,707,070
Total		$1,153,886	$910,537	($243,349)	$44,481,012	$40,914,723	($3,566,289)	$648,019,751	$657,058,623	$9,038,872
Budget variance		-21.1%			-8.0%			1.4%		

	7/31/2015	8/22/2015	Change
IP Accounts Receivable	23,037,971	20,577,457	(2,460,514)
OP Accounts Receivable	28,730,929	34,881,657	6,150,728
ACCOUNTS RECEIVABLE:	$51,768,900	$55,459,114	3,690,214
IP Unbilled Receivable	7,098,463	9,598,460	2,499,997
OP Unbilled Receivable	16,718,641	15,114,884	(1,603,757)
UNBILLED RECEIVABLE:	23,817,104	24,713,344	$896,240
	$75,586,004	$80,172,458	$4,586,454

843

EXHIBIT S6

Schedule H, Part I, Section 7 - Financial Assisstance

		FY 2014	3% FY 2015	3% FY 2016
a	Financial Assistance at cost	328,346	338,196	348,342
b	Medicaid	13,083,195	13,475,691	13,879,962
c	Cost of other means-tested government programs		-	
d	Total Financial Assistance	13,411,541	13,813,887	14,228,304
	Other Benefits		-	
e	Community health improvement services and community benefit operations	147,207	151,623	156,172
f	Health professions education	2,658,321	2,738,071	2,820,213
g	Subsidized health services	1,386,130	1,427,714	1,470,545
h	Research	165,239	170,196	175,302
i	Cash and in-kind contributions for community benefit	70,911	73,038	75,229
j	Total Other Benefits	4,427,808	4,560,642	4,697,462
k	Total	17,839,349	18,374,529	18,925,765

Schedule H, Part II - Community Building Activities

		FY 2014	FY 2015	FY 2016
1	Physical improvements and housing	202	208	214
2	Economic development			
3	Community support			
4	Environmental improvements			
5	Leadership development and training for community members			
6	Coalition building			
7	Community health improvement advocacy			
8	Workforce development	169,504	174,589	179,827
9	Other			
10	Total	169,706	174,797	180,041

3%	3%
FY 2017	**FY 2018**
358,793	369,556
14,296,360	14,725,251
14,655,153	15,094,808

160,857	165,683
2,904,819	2,991,964
1,514,662	1,560,102
180,561	185,978
77,486	79,811
4,838,385	4,983,537
19,493,538	20,078,344

FY 2017	**FY 2018**
221	227
185,222	190,778
185,442	191,006

EXHIBIT S7

SAINT FRANCIS Care Policy and Procedure	**Title:** **Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired.**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☒ Saint Francis Medical Group, Inc. ☒ Saint Francis *Care* Medical Group, P.C. ☒ Asylum Hill Family Medicine Center, Inc. ☒ Saint Francis Behavioral Health Group, P.C. ☒ Saint Francis Emergency Medicine Group, P.C.	**Proponent Department** Patient Care	**Number** CLIN.0121	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☐ **Administrative** ☒ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 6/25/2015	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE:

The purpose of this policy is to help ensure quality Patient care by providing guidelines and procedures to assist Saint Francis Personnel (defined below) in providing Effective Communication (defined below) to individuals who are limited English proficient, visually impaired, deaf or hard of hearing, speech impaired, or who have any other disability impairing their ability to communicate (a "Language Service Need").

SCOPE:

This policy applies to all Saint Francis Personnel in their communications with Patients or Companions (defined below) in all acute care and ambulatory clinical areas of the above referenced entities (collectively, "Saint Francis").

DEFINITIONS:

1. The term **"Auxiliary Aids and/or Services"** includes, but is not limited to Qualified Interpreters in-person or through Video Remote Interpreting (VRI) services; note-takers; computer-assisted real time transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices and systems; telephone compatible hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text and video-based telecommunication products and systems, including text telephones (TTYs/TDDs), videophones and captioned telephones; or other methods of ensuring Effective Communication with individuals who are deaf or hard of hearing.

2. The term "**Companion**" means a person who is one of the following:

- a person whom the Patient designates to communicate with Saint Francis Personnel on his or her behalf regarding the Patient's condition or care or to help the Patient act on the information, advice or instructions provided by Saint Francis;
- a person legally authorized to make health care decisions on behalf of the Patient; or
- such other family member, friend, or associate of a Patient who, along with the Patient, is an appropriate person with whom Saint Francis should communicate.

3. The term "**Effective Communication**" means communication that is as clear and understandable to individuals with Language Service Needs as it is for individuals without. More specifically it means the successful joint establishment of meaning wherein Patients/Companions and health care providers exchange information, enabling

Patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both Patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from Patients, and when Patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care. For communication to be effective it must be, timely, provided in a manner and medium appropriate to the significance of the message and the communication abilities of the Patient/Companion.

4. The term "**Non-scheduled Request**" means a situation in which there is less than two (2) hours between the time when a Patient or Companion who is deaf or hard of hearing makes a request for an interpreter and when the services of an interpreter are necessary.

5. The term **"Patient"** means any individual who is seeking or receiving health care services (whether on an inpatient or outpatient basis, including consultations, treatment, scheduling of appointments, discussion of billing issues, attending health education classes, and other health care services) from Saint Francis.

6. The term **"Qualified Interpreter"** means an interpreter who, via a VRI service, telephone, or an onsite appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators. Not all interpreters are qualified for all situations. For example, an interpreter who is qualified to interpret using American Sign Language is not necessarily qualified to interpret orally. Someone who has only a rudimentary familiarity with sign language or finger spelling is not a "Qualified Interpreter" under this Agreement. Likewise, someone who is fluent in sign language but who does not possess the ability to process spoken communication into the proper signs or to observe someone else signing and change his or her signed or finger-spelled communication into spoken words is not a qualified sign language interpreter.

7. The term **"Scheduled Incident"** means situations in which there are two (2) or more hours between the time when an appointment is scheduled and when the services of the a Qualified Interpreter are required.

8. The term **"Saint Francis Personnel"** means all employees and independent contractors with contracts to work for Saint Francis, including, without limitation, nurses, physicians, social workers, technicians, admitting personnel, receptionists, telephone operators, billing staff, security staff, counselors, and therapists, and all volunteers, who have or are likely to have direct contact with Patients or Companions as defined herein. The term also includes all affiliated physicians or other health care professionals who have medical staff privileges that permit them to see and/or treat Patients at Saint Francis. Saint Francis will ensure that all Saint Francis Personnel receive training in Language Services appropriate to their role and level of direct contact with Patients and Companions.

9. The term **"Video Remote Interpreting" ("VRI")** means an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images and meets other requirements as provided in 28 C.F.R. §36.303(f).

POLICY:

Commitment to Provide Effective Communication

Saint Francis shall provide its Patients and their Companions with Effective Communication and an equal opportunity to participate fully in the benefits, activities, programs and services provided by Saint Francis in a timely manner and in such a way as to protect the privacy and independence of the individual.

Where necessary to ensure Effective Communication, Saint Francis shall provide appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, to Patients and Companions who are Limited English Proficient (LEP), visually impaired, deaf or hard of hearing, speech impaired or who have another disability which impairs their ability to communicate (collectively, "Language Service Needs"). Saint Francis shall make a site specific determination of which Auxiliary Aids and/or Services will be available at each of its separate locations.

Patients and Companions of Saint Francis, who are LEP shall have services provided to them in their primary language or have appropriate Auxiliary Aids and/or Services, including the services of a Qualified Interpreter provided to them during the delivery of all significant healthcare and related support services.

All Auxiliary Aids and/or Services shall be available within a reasonable time, at no cost to Patients as needed to provide Effective Communication.

Assessment of Communication Needs:

Assessment of Need for Auxiliary Aids and/or Services. Saint Francis Personnel shall perform an assessment to determine whether the Patient or Companion requires Auxiliary Aids and/or Services to ensure Effective Communication ("Assessment of Language Needs"). If there is any indication from such initial assessment, inquiry, or Saint Francis Personnel's observations of the Patient or Companion, that the Patient or Companion has a Language Service Need, Saint Francis Personnel shall perform an assessment to determine which appropriate Auxiliary Aids and/or Services are needed in order to ensure Effective Communication. In determining which Auxiliary Aids and/or Services are necessary to ensure Effective Communication, and the timing, duration, and frequency with which they will be provided, Saint Francis Personnel shall consult with the Patient or Companion who has a Language Service Need. The assessment shall consider and take into account all relevant facts and circumstances, including without limitation the following:

- the Patient's or Companion's request for, stated need, or preference for, a Qualified Interpreter or other specific Auxiliary Aids and/or Services;
- the nature, length, complexity, and importance of the communication at issue;
- the individual's disability and communication skills and knowledge;
- the Patient's health status or changes thereto;
- the reasonably foreseeable health care activities of the Patient (e.g., medical tests or procedures, rehabilitation services, meetings with health care professionals or social workers, discussions regarding billing, insurance, self-care, prognoses, history, and discharge); and
- any factors relevant to determine whether the specific type of Auxiliary Aid and/or Service is effective under the circumstances as set forth below.

A list of communication options will be provided to the Patient/Companion to determine their preferred communication method(s). A Patient or Companion with a Language Service Need may prefer to use lip reading, paper and pencil or pictorial cards during the initial Assessment of Language Need.

Timing of Assessment and Determination. Saint Francis Personnel shall provide the initial Assessment of Language Needs at the first point at which a Patient accesses services at Saint Francis (emergency department registration, admissions, etc.). Saint Francis shall incorporate the Assessment of Language Needs into its electronic medical record and its intake procedures and document its determination in the patient's medical record, including substantially all of the elements set forth in the Communication Assessment and Waiver attached hereto as Attachment A. The Assessment of Language Needs shall be conducted at the earliest of the following:

- the time an appointment is scheduled;
- the time Saint Francis becomes aware that a Patient or Companion who has a Language Service Need

who may require Auxiliary Aids and/or Services is being transferred or transported to Saint Francis; or

- the time the Patient or Companion initially arrives at Saint Francis or encounters Saint Francis Personnel.

Ongoing Assessment and Redetermination. On an on-going basis, Saint Francis Personnel shall reassess their determination of whether Effective Communication is being provided, in consultation with the Patient or Companion who has a Language Service Need, when the Patient or Companion indicates that communication has not been effective, or when Saint Francis Personnel's observations suggest that communication has not been effective. The on-going Assessment of Language Needs shall be conducted during Patient care as needed and the Auxiliary Aids and/or Services shall be amended if required based on the findings of the on-going assessment.

Continuation of Provision of Appropriate Auxiliary Aids and/or Services for Continued Hospitalizations and Subsequent Visits. If a Patient or Companion who has a Language Service Need has an ongoing relationship with Saint Francis, with respect to each of the subsequent visits, Saint Francis shall continue to provide appropriate Auxiliary Aids and/or Services to the Patient or Companion during the entire period of the Patient's hospitalization and/or outpatient visits, without requiring subsequent assessments or requests for the appropriate Auxiliary Aids and/or Services by the Patient or Companion unless the Patient or Companion indicates otherwise.

Documentation of Assessment and Determination. The Assessment and determination of Language Needs shall be documented in the Patient's medical record. The Patient's medical record shall be conspicuously labeled to alert Saint Francis Personnel to the fact that the Patient or Companion has a Language Service Need and any Auxiliary Aids and/or Services that have been identified as necessary to Provide Effective Communication with the Patient or Companion.

Determination Not to Provide Requested Auxiliary Aid or Service. If, after conducting the Assessment of Language Needs, Saint Francis determines that it will not provide a particular Auxiliary Aid or Service requested by a Patient or Companion who has a Language Service Need, Saint Francis Personnel shall so advise the individual requesting the Auxiliary Aid or Service. In the event that an Auxiliary Aid or Service is necessary for Effective Communication and Saint Francis Personnel determine that they will not provide the Auxiliary Aid or Service requested by the Patient or Companion who has a Language Service Need, Saint Francis Personnel will secure and provide the Patient or Companion with another means of Effective Communication. Saint Francis Personnel shall document in the Patient's medical record the basis for the determination, including the date of the determination; the name and title of the Saint Francis Personnel who made the determination; and the alternative Auxiliary Aid or Service, if any, that Saint Francis provided.

Exchange of written notes. In determining whether the exchange of written notes, using either paper and pen or a mobile device, is Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include the Patient's or Companion's fluency in written English.

Lip Reading. In some circumstances, lip reading may be a means of Effective Communication. In determining whether communication using lip reading is appropriate and Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include:

- the Patient's or Companion's fluency in English;
- the Patient's or Companion's competency in lip reading; and
- whether the Patient or Companion has residual hearing.

<u>Provision of Qualified Interpreter Services</u>:

Provision of Qualified Interpreter. Saint Francis shall provide a Qualified Interpreter to a Patient or Companion whenever needed for Effective Communication. The following are examples of circumstances when it is necessary to provide Qualified Interpreters:

- Obtaining a Patient's medical history or description of symptoms and medical condition;
- Discussing or explaining a Patient's diagnosis, current condition, prognosis, treatment options or recommendation for treatment;
- Explaining Patient rights and responsibilities;
- Discussing or explaining procedures, tests, or treatments;
- Discussing or explaining test results;
- Discussing or explaining prescribed medications, instructions for how and when medication is to be taken, and possible side effects and interactions of medications;
- Obtaining informed consent or permission for procedures, surgery, or other treatment options;
- Communicating during treatment and testing;
- Communicating during discharge or post-operative planning and instruction;
- Providing mental health evaluations, group or individual therapy, counseling or other therapeutic activities, including, but not limited to, grief counseling and crisis intervention;
- Providing information about blood or organ donations;
- Explaining living wills or powers of attorney (or their availability);
- Discussing financial or insurance matters related to payment for services;
- Providing educational presentations, such as classes concerning birthing, nutrition, cardiopulmonary resuscitation (CPR), and weight management;
- Any other circumstance in which a Qualified Interpreter is necessary to ensure a Patient's rights provided by the law.

The foregoing list of circumstances is not exhaustive and does not imply that there are no other circumstances when it may be appropriate to provide Auxiliary Aids and/or Services for Effective Communication.

Acceptable methods for the provision of Qualified Interpreter and translation services include, but are not limited to the following:

- Telephone-based interpreting- delivered via telephonic technology
- Video Remote interpreting (VRI)- video conference with a Qualified Interpreter (including but not limited to American Sign Language (ASL))
- In-person interpreting- provided onsite by a Qualified Interpreter (including ASL)
- Written translation of vital and non-vital documents (vital documents as determined by the Joint Commission, Department of Health and Human Services and other regulatory agencies)

Whenever possible, arrangements for Qualified Interpreters/equipment should be made in advance when Patients have scheduled appointments. Telephone Qualified Interpreter services are available on each unit and will be used whenever appropriate if there is a delay in the delivery of resources. For deaf and hard of hearing Patients the VRI resources can be used if there is a delay in arrival of in-person resources.

The following resources and/or devices may be utilized at **no charge to the Patient.**

A. <u>Deaf or Hard of Hearing</u>

Pictorial Cards (located in the language resource box)
Amplified Handset/Volume Control Telephone

Large Button Telephones
Telephone Typewriter (TTY)
Video Remote Interpreter (VRI) (With Qualified Interpreter communication including but not limited to ASL)
Contracted onsite Qualified Interpreters (including but not limited to ASL)

B. Visually Impaired

Braille Telephones

C. Limited English Proficient

- Pictorial Cards (located in the language resource box)
- Telephone interpreting (telephone based language interpretation)
- Video Remote interpreting (including but not limited to ASL)
- In-person interpreting (including but not limited to ASL)
- Written translated documents

Procedures for Obtaining Language Service Resources

Procedure For Obtaining A Telephone Qualified Interpreter:
If the Patient wishes to utilize the telephone Qualified Interpreter, Saint Francis Personnel will phone the hospital operator by dialing **'0'** from any phone and request to be connected to language resources. Dual handset phones are available on all units that are preprogrammed to dial language resources directly.

The requesting staff will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

Procedure For Obtaining A Video Remote Interpreter (VRI) Device:
The requesting staff shall first make a determination as to whether communication using VRI is appropriate and effective. Relevant factors in making such determination include whether:

- The Patient or Companion is limited in his or her ability to see the video screen;
- The Patient or Companion has limited ability to move his or her head, hands, or arms; vision limitations, cognitive or consciousness issues, or pain issues;
- There are multiple people in a room and the information exchanged is highly complex or fast-paced;
- The Patient or Companion may move repeatedly to areas of Saint Francis that do not have a designated high speed internet line; and
- The Patient will be treated in a room where there are space restrictions.

1. If the requesting staff determines that VRI is appropriate, they shall phone the hospital operator, dial '0'

and request the VRI device be brought to the Patient.

The requesting Saint Francis Personnel shall provide the following:

- Name and telephone number of requester,
- Department - including campus and address,
- Patient name and reason for visit,
- Date, time and approximate length of time needed,
- Additional assistance that may be needed

2. The hospital operator will validate that the Patient is in an area that has wireless communication.

3. The hospital operator will notify the storeroom via phone to request the VRI device on behalf of the Patient.

4. The VRI device will be deployed to the requesting department within 10 minutes, if available. Storeroom staff will complete the storeroom VRI device log.

5. The equipment will be placed in a location that is easily viewed by both the Patient and the Saint Francis Personnel, generally near the foot of the bed or stretcher (or according to Patient abilities), with the Saint Francis Personnel standing near the Patient at the head of the bed during the interpretation session.

6. The Saint Francis Personnel will initiate the connection and answer a number of required questions such as Patient's name, medical record number, location, etc. before beginning the interpretation session.

7. Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of the response in the medical record. In the event that the Patient or Companion cannot communicate effectively using any VRI service and alternative resource will be employed.

8. The VRI will facilitate communication between the Saint Francis Personnel and the Patient/Companion. NOTE:

a. The camera and sound system will pick up EVERYTHING that is said and done in the room and EVERYTHING will be interpreted to the Patient. There is no selective interpreting.

b. In the event of a system connectivity failure, the Saint Francis Personnel should notify the operator of equipment failure, the operator will request technical support and/or request a replacement VRI. In the event that a repair or replacement VRI is not available in a timely manner Saint Francis Personnel shall obtain an alternative means of Effective Communication in accordance with this policy or follow the procedures outlined below for Interim Services until a repair or replacement VRI is secured.

9. The same Patient may require the VRI device several times during a single hospital visit. The Saint Francis Personnel must disconnect at the end of each session or whenever they leave the room and reconnect as needed to start a new session.

10. The Saint Francis Personnel must document in the Patient's medical record each time the equipment is utilized with dates and start and stop times of each interpretation session and effectiveness of communication method.

11. When the VRI equipment is no longer required, the Saint Francis Personnel will place the VRI in the dirty laundry area for pick up by storeroom staff.

Saint Francis shall ensure that VRI services are provided in accordance with the following standards:

- real-time, full-motion video and audio over a dedicated, high-speed, wide-bandwith video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
- a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating Patient or Companion's face, arms, hands, and fingers, regardless of his or her body position;
- a clear, audible transmission of voices;
- ensure that the interpreter providing VRI is a Qualified Interpreter who is capable of communicating effectively with the Patient or Companion; and
- users of the technology and other involved individuals are adequately training so that they may quickly and efficiently set up and operate the VRI.

Once the VRI is operating, Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of his or her response. In the event that the Patient or Companion cannot communicate effectively using any VRI service the Hospital elects to acquire and offer, Saint Francis shall make all reasonable efforts to locate an in-person Qualified Interpreter or other Auxiliary Aid or Service that will provide Effective Communication; periodically inform the Patient or Companion of the status of those efforts; and document the concern and the steps taken to locate a Qualified Interpreter.

Procedure For Obtaining An In-Person Qualified Interpreter (including ASL):
The requesting Saint Francis Personnel will phone the hospital operator, dial '0' to request in-person Qualified Interpreter services. Operators will schedule these services including in-person Qualified Interpreters and will provide requesting Saint Francis Personnel with approximate time of arrival. They may or may not be immediately available due to weather restrictions etc., however, all services will be provided within a two hours of Non-scheduled Requests. If an in-person ASL Qualified Interpreter is not available, the VRI will be used for ASL Interpretation and the reason why the in-person Qualified Interpreter was not available must be noted in medical record. In the event that an Auxiliary Aid and/or Service is necessary and Saint Francis Personnel determines that it will not provide a particular Auxiliary Aid and/or Service requested by the Patient or Companion who has a Language Service Need, the requesting Saint Francis Personnel shall document the basis for the determination, including the date of the determination, the name and title of the Saint Francis Personnel who made the determination, and the alternative Auxiliary Aid and/or Service, if any, that Saint Francis decided to provide, in an Auxiliary Aid and Service Log. A copy of this documentation shall be retained and a copy shall be provided to the Patient or Companion upon request.

The requesting Saint Francis Personnel will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

The Saint Francis Personnel will document the arrival time of the Qualified Interpreter in the Patient's medical record

including the length of time for the interpretive session and effectiveness of the communication method. Each interpretive session must be documented separately. The same Patient may require the Qualified Interpreter several times during a single hospital visit, as additional communications are needed.

Procedure for the Provision of Written Translations:

1. Vital documents as defined by the Joint Commission and the Department of Health and Human Services will be translated and made available to Patients/Companions. These documents include but are not limited to:
    - Patient Rights and Responsibilities
    - Informed Consent
    - Advanced Directives
    - HIPPA Forms
    - Discharge Instructions
    - Release of Information
    - Notices pertaining to denial, reduction, modification or termination of services
    - Grievance forms

    Documents will be translated into each primary language used by more than 15% percent of the Patient population (each a "Frequently Utilized Language"). This will be assessed on an annual basis.

Provision of Qualified Interpreters in a Timely Manner:

When an interpreter is necessary for Effective Communication, Saint Francis shall ensure that Qualified Interpreters are provided in a timely manner.

Provision of Qualified Interpreter for Scheduled Incidents. For Scheduled Incidents, when a Qualified Interpreter is necessary to ensure Effective Communication, Saint Francis shall make a Qualified Interpreter available at the time of the appointment. If a Qualified Interpreter fails to arrive for the appointment, Saint Francis shall immediately contact the Qualified Interpreter service or another resource to arrange for another Qualified Interpreter.

Provision of Qualified Interpreter for Non-scheduled Requests. For Non-scheduled Requests, Saint Francis shall make a Qualified Interpreter available as soon as practicable, but no later than (a) two (2) hours from the time the request for an in-person Qualified Interpreter is made or (b) within fifteen (15) minutes of the request for a Qualified Interpreter when providing a Qualified Interpreter through VRI.

Interim Services. Between the time a Qualified Interpreter is requested and the time a Qualified Interpreter arrives, Saint Francis Personnel shall continue to try to communicate with the Patient or Companion who is deaf or hard of hearing for such purposes and to the same extent as they would have communicated with an individual without a disability, using all methods of communications. Saint Francis shall inform such Patient (or a Companion, if such Patient is unavailable) of the current status of efforts being taken to secure a Qualified Interpreter on his or her behalf. This section is not intended to delay the provision of appropriate medical care and services.

Provision of Qualified Interpreter throughout Hospitalization. Saint Francis shall provide a Qualified Interpreter throughout the admission of a Patient as necessary to achieve Effective Communication with such Patient or their Companion.

Communication Restrictions:

Restricted Use of Minors to Facilitate Communication. Saint Francis shall not rely on a minor accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or

Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public and where there is no Qualified Interpreter available.

Limited Use of an Adult Accompanying a Patient or Companion to Facilitate Communication. Saint Francis shall not require a Patient or Companion to bring another individual to interpret for him or her. Saint Francis Personnel may not rely upon an adult accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no Qualified Interpreter available or unless the following four factors are present:

- where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication and such person agrees to provide such assistance;
- such use is necessary or appropriate under the circumstances, giving appropriate consideration to any privacy and confidentiality issues that may arise;
- the Patient or Companion has been made aware of Saint Francis's full range of Auxiliary Aids and/or Services available free of charge; and
- the Patient or Companion provides written confirmation, substantially in the form of the Waiver of Interpreter Services Provided by Saint Francis attached hereto as Attachment A, that he or she was made aware of relevant Auxiliary Aids and/or Services available free of charge and agrees to the use of such person to interpret or facilitate communication. In such situations, Saint Francis shall retain the above-required written documentation in the Patient's medical record.

Notices:
Saint Francis shall develop, and post in conspicuous locations, notices that advise Patients and their families of the availability of Qualified Interpreters, the procedure for obtaining a Qualified Interpreter and the telephone numbers where complaints may be filed concerning Qualified Interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. All areas of first Patient contact shall be equipped with Language Determination Cards to assist Patients in identifying the Patient's primary language if communication barriers prevent Saint Francis Personnel from effectively determining the language of the Patients/Companions.

Training
New employees of Saint Francis will be trained in the procedure for the acquisition of Qualified Interpreter services during their employee orientation. Training on this procedure for current Saint Francis Personnel is required on an annual basis via on-line Health Stream training. In-person training is available on request to all Saint Francis departments, units and programs that require further assistance. Quarterly trainings will be held for the operators to ensure they are updated on all language services. Operators will fulfill the 24/7 requirement of an in-person language services point-person (with Clinical Resource Coordinators as back up) when the Language Services Program Administrator is off-site.

A poster outlining the availability of language services has been installed at all nursing stations and other points of Patient registration throughout the hospital and The Language Services Program Administrator (defined below), or his/her designee, shall conduct bi-monthly audits of such signage to ensure it remains in place and updated as necessary.

The Language Services Program Administrator shall conduct an annual review of the Language Services Needs of the Patient population. Following such review, the Language Services Program Administrator shall update the list of Frequently Utilized Languages and recommend any necessary changes to this policy.

Language Services Program Administrator
Saint Francis has designated a program administrator (the "Language Services Program Administrator"). The

Language Services Program Administrator, or his/her designee shall be available twenty-four (24) hours a day, seven (7) days a week, to answer questions and provide appropriate assistance regarding immediate access to, and proper use of, the appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, required by this policy. The Program Administrator may be reached at (860) 714-7004 or, for non-urgent enquiries, via email @ [*EMAIL ADDRESS*]. Auxiliary Aids and/or Services can be requested by dialing the Saint Francis operator (860) 714-4000 or "0" internally. Additional information on language services may be found on the Language Services website, by clicking the "3+1 Language Services Program" icon on the Saint Francis Infonet.

STATUTORY, REGULATORY OR OTHER REFERENCES/POLICY CROSS REFERENCE:

Section 504 of the Rehabilitation Act of 1973
Title III of the Americans with Disabilities Act (ADA)

CROSS REFERENCES:

Disability Discrimination Complaint and Grievance Policy

APPROVED BY: Policy requires Vice President approval.

Vice President(s):	Date:	Committee(s), if applicable:	Date:
Patti LaMonica, R.N. M.S.N. Interim Vice President Professional Nursing Practice and Quality Interim Chief Nursing Officer Executive Director Emergency and Pre-hospital Service Line	6/25/2015	Surendra P. Khera MD MSc Vice President, Medical Affairs Chief Medical Officer |Chief Quality Officer Vice-Chair, Department of Medicine.	6/25/2015

REPLACES:

Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired, 4/16/2015

KEY CHANGES:

Procedures for request of services broadened and clarified.

Attachment A

Communication Assessment and Waiver

It is the policy of Saint Francis to provide Auxiliary Aids and/or Services free of charge to ensure effective communication with Patients and Companions who are deaf, are hard of hearing, or have speech disabilities. We ask these questions so we may communicate effectively with you.

Patient's Name: _____

Name of Person with Disability (if not Patient): _____

Completed by: _____ Date & Time: _____ am/pm

Nature of Disability:

- ❑ Deaf
- ❑ Hard of Hearing
- ❑ Speech Disability
- ❑ Other (explain) _____

Relationship to Patient:

- ❑ Self
- ❑ Family Member
- ❑ Friend
- ❑ Other (explain) _____

Is a Qualified Interpreter necessary to assist in communicating with Hospital staff?

❑ Yes. Choose type:
❑ American Sign Language (ASL)
❑ Signed English
❑ Oral interpreter
❑ Cued speech
❑ Other (explain) _____

❑ No. Choose one:
❑ I do not use sign language or do not use an interpreter.
❑ I prefer to have family members/friends help with communication.
❑ I do not feel an interpreter is necessary or do not want one for this visit.
❑ Other (explain) _____

If you select No, please complete the Waiver of Interpreter Services (below).

All Communication Services will be provided FREE OF CHARGE.

If you requested an interpreter, do you have a preference between an in-person interpreter or a VRI?

❑ Yes, I prefer an interpreter in-person.

❑ Yes, I prefer video remote interpreter.

❑ No, I do not have a preference between the two.

Are other Auxiliary Aids and/or Services necessary for assisting with communication? Select all that apply:

❑ TTY/TDD (text telephone)

❑ Assistive listening device (sound amplifier)

❑ Qualified note-takers

❑ Exchange of written notes (writing back-and-forth)

❑ Relay

❑ CART (Computer-assisted Real Time Transcription Service)

❑ Other (explain) _____

If you have any questions, please call_____(voice),_____(TTY).

Signature_____Date & Time _____ Relationship to Patient_____

WAIVER OF INTERPRETER SERVICES PROVIDED BY SAINT FRANCIS

It is your choice whether you use an interpreter provided by Saint Francis. You are indicating that Saint Francis has offered to provide you with an interpreter, free of charge, and that you have declined Saint Francis offer.

❑ I waive my right to request that [*name of facility*] provide me an interpreter for this specific encounter.

❑ I have been informed of range of auxiliary aids and services that are available free of charge.

❑ I have been informed that [*name of facility*] does not require a Patient or Companion to bring someone to interpret for him or her.

❑ I request that_____(name of individual to interpret for Patient or Companion) to interpret or facilitate communications between [*name of facility*] personnel and the Patient or Companion.

Signature_____Date & Time _____ Relationship to Patient_____

If at any point during your Hospital visit, you wish to change any of the answers to the questions on this form or revoke your waiver, please notify_____.

EXHIBIT S8

The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review

Glenn Flores
Medical College of Wisconsin

Abstract

Twenty-one million Americans are limited in English proficiency (LEP), but little is known about the effect of medical interpreter services on health care quality. A systematic literature review was conducted on the impact of interpreter services on quality of care. Five database searches yielded 2,640 citations and a final database of 36 articles, after applying exclusion criteria. Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpreter services can have serious consequences for patients with mental disorders. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

Published in Medical Care Research Review

Med Care Res Rev **June 2005** vol. 62 no. 3 **255-299**

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

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ONE HUNDRED AND THIRD ASSEMBLY DISTRICT

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PUBLIC HEATH COMMITTEE
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10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

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State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ROBERT SAMPSON
EIGHTIETH ASSEMBLY DISTRICT

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JUDICIARY COMMITTEE

10/26/2015

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Sincerely,

Representative Rob Sampson
80th District

State of Connecticut
SENATE

SENATOR HENRI MARTIN
THIRTY–FIRST SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
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WEBSITE: www.SenatorHenriMartin.com

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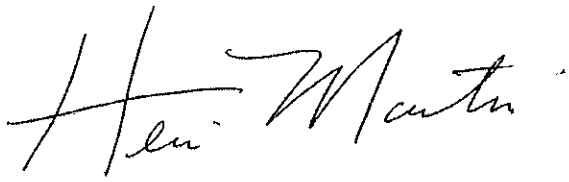

Senator Henri Martin
31st District

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

November 4, 2015

The Honorable Henri Martin
Senate Minority Whip
31st Senate District
State of Connecticut
Legislative Office Building, Suite 3400
Hartford, CT 06106-1591

Re: Certificate of Need
Saint Mary's application to sell its assets to Trinity Health Corporation

Dear Senator Martin:

On November 2, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket once it is received. Please be advised, that once a hearing has been scheduled it will be posted on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Connecticut Department of Public Health

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Jewel Mullen, M.D., M.P.H., M.P.A.
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Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

November 4, 2015

The Honorable Al Adinolfi
Assistant Republican Leader
103rd Assembly District
State of Connecticut
Legislative Office Building, Room 4200
Hartford, CT 06106-1591

Re: Certificate of Need
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Dear Representative Adinolfi:

On October 26, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

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Lt. Governor

November 4, 2015

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Representative
80th Assembly District
State of Connecticut
Legislative Office Building, Room 4200
Hartford, CT 06106-1591

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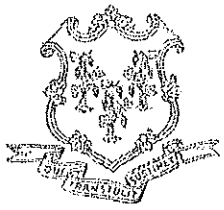

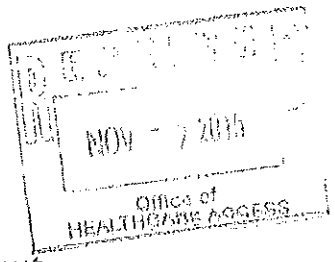

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31st District

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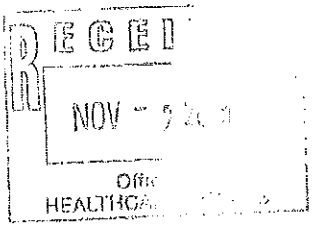

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ROBERT SAMPSON
EIGHTIETH ASSEMBLY DISTRICT

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10/26/2015

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As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

ST. FRANCIS XAVIER RECTORY
625 BALDWIN STREET
WATERBURY, CONNECTICUT 06706
(203) 756-7804 ◦ Fax (203) 756-7805

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NOV 13 2015
Office of
HEALTHCARE ACCESS

November 12, 2015

Kimberly R. Martone, Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding *it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with* Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Paul J. Pace
Pastor

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RECEIVED
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REPRESENTATIVE CRAIG A. MINER
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

HOME: (860) 567-4757
CAPITOL: (800) 842-1423
Craig.Miner@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
State Representative
66th District

NOSS
Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery
Michael E. Karnasiewicz, MD, ABNS
Neurosurgery & Spine Care
Jarob N. Mushaweh, MD, ABNS
Neurosurgery & Spine Care
Alan S. Waitze, MD, ABNS
Neurosurgery & Spine Care
John G. Strugar, MD
Neurosurgery & Spine Care
David L. Forshaw, MD
Neurosurgery & Spine Care
Judith L. Gorelick, MD, FAANS, FACS
Neurosurgery & Spine Care

Orthopaedics
Glenn G. Taylor, MD, ABOS
Orthopaedic Surgery & Spine Care
William F. Flynn, Jr., MD, ABOS
Joint Reconstruction & Sports Medicine
Frederick J. Watson, MD, ABOS
Orthopaedic Surgery & Sports Medicine

Pain Management
and Rehabilitation
Tamer B. Ghaly, MD
Interventional Pain Management
Thomas Mathew, MD
Interventional Physiatry
Alisa H. Darling, MD, ABPMR
Physical Medicine & Rehabilitation
Electrodiagnostic Medicine
Mark A. Mashia, DC, MS
Chiropractic Physician, Acupuncture

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November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System.

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

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Office of
HEALTHCARE ACCESS

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

The healthcare environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis, together with their ultimate acquisition by Trinity Health Corporation, will give both Catholic hospitals the support that is essential to be successful. Together they plan to improve the infrastructure and capabilities required to deliver value-based accountable care; improve population health; enhance the quality of care; reduce the cost of healthcare; expand services; and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent, and capital to keep the safety network for healthcare alive and well. While Saint Mary's is a strong hospital, the demands of the new healthcare laws and high cost of

technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,

Larry B. Butler

Larry B. Butler
State Representative

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

December 2, 2015

The Honorable Larry B. Butler
Representative -72nd District
House of Representatives
Legislative Office Building
Hartford, CT 06106-1591

Re: Certificate of Need Docket Number 15-32045-CON
Saint Mary's Health System
Saint Mary's application to sell its assets to Trinity Health-New England, Inc.

Dear Representative Butler:

On November 27, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Health System's application to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

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Office of
HEALTHCARE ACCESS

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

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technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,

Larry B. Butler

Larry B. Butler
State Representative

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: December 16, 2015

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.
Transfer of Ownership and Control to Trinity Health-New England, Inc.,
formerly known as Saint Francis Care, Inc.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Thursday, December 24, 2015 2:32 PM
To: 'chartley@stfranciscare.org'; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information
Attachments: 15-32045 Completeness Letter 12.24.15.pdf

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 24, 2015

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Dadlez and Mr. Anthony:

On November 25, 2015, the Office of Health Care Access received a Certificate of Need application filing on behalf of Saint Mary's Health System ("SMHS") and New England Regional Health Ministry ("NE-RHM"), a subsidiary of Trinity Health Corporation ("THC"), for NE-RHM to acquire SMHS and its assets. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **February 22, 2016**, otherwise your application will be automatically considered withdrawn.

OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a-639a(c) and requests the following additional information:

1. What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.

2. Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.

3. Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.

4. According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.

5. What entity will be doing the billing for Saint Mary's if the CON is approved?

6. Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.

7. With respect to the $100 million capital expenditure and two additional $10 million payments:

    a) List all sources of funding and financing.
    b) What portion of the payment will be derived from Saint Mary's operational revenue?
    c) Is payment of the full $100 million amount contingent upon financial performance?
    d) Will Saint Mary's future income be:
        i. Used to fund the payment?
        ii. If so, in full or in part?
        iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.
    e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?
    f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?
    g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?

8. Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:

    a) Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.
    b) Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?

c) Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years
d) If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.
e) Are there specific projects the additional funding will be used for?

9. Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:

a) Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.
b) What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?
c) What are the specific facility upgrades that are needed for $22 million?
d) What types of clinical equipment is going to be purchased for $18 million?
e) Explain the clinically integrated network development expenditure of $5 million.
f) Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.

10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.

11. Regarding the long term debt and the SMHS retirement plan, respond to the following:

a) Explain further the unfunded pension obligations including providing the current funded status of the plan.
b) Explain future plans to address the debt obligations including the rates being paid presently and the rates that would apply if the debt was refinanced.

12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?

13. What attempts were made to restructure debt under the current management structure?

14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.

15. Which entities are included in the NE-RHM financial worksheet data on page 441?

16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:

    a) List all hospitals THC has integrated into its system over the past three years.
    b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.

17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.

18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.

19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?

20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?

21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.

22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?

23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.

24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."

a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.
b) Indicate what services will likely be eliminated.

25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:

a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.
b) Other Operating Revenue remains the same in FYs 2016 – 2019.
c) There are no self-pay revenues provided in any of the years.
d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.

If you have any questions concerning this letter, please feel free to contact either me at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

Jessica Schaeffer-Helmecki
Jessica.schaeffer-helmecki@ct.gov
Planning Analyst

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Thursday, December 24, 2015 2:36 PM
To: Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
Subject: RE: Request for more information

I have received the e-mail.
Merry Christmas and Happy New Year.
Chris Hartley

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Thursday, December 24, 2015 2:32 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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From:	Attorney Bob Anthony
To:	"Hartley, Christopher"; Schaeffer-Helmecki, Jessica
Cc:	Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; "Rotavera, Liz"
Subject:	RE: Request for more information
Date:	Thursday, December 24, 2015 2:36:48 PM

I also received the email. Thank you. Happy holidays.

Bob Anthony

Sent with Good (www.good.com)

-----Original Message-----
From: Hartley, Christopher [CHartley@stfranciscare.org]
Sent: Thursday, December 24, 2015 02:35 PM Eastern Standard Time
To: Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
Subject: RE: Request for more information

I have received the e-mail.
Merry Christmas and Happy New Year.
Chris Hartley

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Thursday, December 24, 2015 2:32 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
Subject: Request for more information

Mrrs. Hartley and Anthony:

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Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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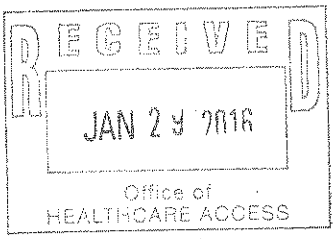
Saint Mary's HOSPITAL | Trinity Health New England

January 29, 2016

Via Hand Delivery



Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis Care, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find the original and CD containing our responses to OHCA's December 24, 2015 letter regarding the above referenced Certificate of Need application.

If you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: _____
Robert Anthony
General Counsel
Saint Mary's Health System

By: _____
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

Saint Mary's HOSPITAL | Trinity Health New England

January 29, 2016

Via Hand Delivery

Jessica Schaeffer-Helmecki
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R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

1. **What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.**

   The entity known as Saint Mary's Health System will be dissolved leaving Saint Mary's Hospital (Saint Mary's) as the surviving entity. The Trinity Health - New England entity will replace Saint Mary's Health System as the sole member of Saint Mary's Hospital. **Exhibit 24** reflects the proposed structure.

2. **Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.**

   Saint Mary's, along with Waterbury Hospital are both committed to ensuring that the services offered by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury continue to be offered to the greater Waterbury community. We will continue to work collaboratively and do understand that any changes that fall under the purview of the CON statutes will require both organizations to appropriately notify OHCA.

3. **Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.**

   Please see **Exhibit 25** (Saint Mary's Health System Amended and Restated Certificate of Incorporation) and **Exhibit 26** (Saint Mary's Health System Amended and Restated Bylaws).

4. **According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.**

   CON 07-31003 gave Connecticut Children's Medical Center the approvals to operate an Inpatient Pediatric Medical Surgical Unit on the Saint Mary's Hospital Campus. The neonatal ICU program, which existed before CCMC became involved with Saint Mary's Hospital, and continues to be a Saint Mary's Hospital program supporting the hospital's maternity program, and was not included in this ruling. Please see **Exhibit 27** for the Agreed Settlement. No other hospital's discharge data is included in the historical and projected data.

5. **What entity will be doing the billing for Saint Mary's if the CON is approved?**

   Saint Mary's Hospital will continue to bill as it currently does. There is no anticipated change in Saint Mary's current billing practices related to this proposal.

6. **Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.**

As noted in Section 4.01 Capital Commitment of the Transfer Agreement between Trinity Health /NE-RHM and Saint Mary's ("Transfer Agreement"), "Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than $120,000,000 subject to the achievement of the performance metrics in years four and five, to support operations of Saint Mary's and Saint Mary's controlled subsidiaries." This $100M capital commitment is part of the $275M capital commitment Trinity Health made to Saint Francis Care, Inc. as noted in CON #15-31979-CON. Trinity Health is responsible to ensure the $275M capital commitment to Saint Francis Care, Inc. (now the NE-RHM) and the NE-RHM is responsible to ensure $100M of this capital is allocated to Saint Mary's. Please see **Exhibit 28** for the documentation of the commitment.

7. With respect to the $100 million capital expenditure and two additional $10 million payments:

a) List all sources of funding and financing.

The sources of funding as agreed to in Section 4.01 of the Transfer Agreement are:

1. Available cash and investments generated by Saint Mary's;
2. Financing obtained through the Trinity Health system debt program; and, to the extent necessary,
3. Capital contributions from Trinity Health

The goal of the NE-RHM is for its subsidiaries to support their capital investments with their own cash flow. If Trinity Health, NE-RHM and Saint Mary's determine that financing the capital investments is more prudent than utilizing Saint Mary's cash generated from operations then the NE-RHM will access the Trinity Health debt program on behalf of Saint Mary's. For example, despite Saint Mary's generating sufficient cash flow for these expenditures, NE-RHM, Trinity Health and Saint Mary's may determine it is more prudent to maintain its current cash position and instead finance Saint Mary's capital investments. In this case, the NE-RHM, through Trinity Health, would provide financing to Saint Mary's for these capital investments.

b) What portion of the payment will be derived from Saint Mary's operational revenue?

The $100M of capital allocated to Saint Mary's is not a payment. It is a commitment to ensure an allocation of capital investment to Saint Mary's. The $100M of capital will be funded as noted in 7a above.

c) Is payment of the full $100 million amount contingent upon financial performance?

The allocation of $100M of capital investment is not contingent upon Saint Mary's financial performance.

d) Will Saint Mary's future income be:

i. Used to fund the payment?

Any of Saint Mary's cash flow can be used to pay for its capital expenditures as long as its use does not compromise Saint Mary's ability to fulfill its financial obligations.

ii. If so, in full or in part?

After review of the capital expenditure need and Saint Mary's balance sheet, it will be determined whether the capital expenditure will be funded by Saint Mary's cash flow partially or fully and, if only partially, the remainder of the capital expenditure will be financed using the Trinity Health debt program.

iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.

As noted in 7a above, if Saint Mary's cannot generate sufficient cash flow to fund a capital expenditure, the NE-RHM can obtain financing for the capital expenditure through the Trinity Health debt program.

e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?

As noted in paragraph 4.01 of **Exhibit 28**, only $20 million of the capital investment is contingent upon achieving financial performance metrics.

f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?

The allocation would be determined after the closing of the transaction in conjunction with NE-RHM based on Saint Mary's capital needs and the NE-RHM strategic and current priorities. NE-RHM will follow the Trinity Health system capital approval process, which will require NE-RHM approval for capital expenditures. Capital expenditures will also be subject to the Trinity Health governance matrix, which dependent on the level of a particular capital expenditure may require Trinity Health management or governance approval. Trinity Health management approval is typically for capital expenditures greater than $5M but less than $25M and capital expenditures greater than $25M require Trinity Health governance approval.

g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?

As deemed necessary by Trinity Health and NE-RHM, financing from Trinity Health System's debt program would be available to fund capital expenditures.

8. Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:

a) Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.

Payment is dependent upon the consolidated financial performance of Saint Mary's Hospital and its controlled subsidiaries achieving the operating cash flow margins as indicated in the Transfer Agreement.

b) Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?

This is the sole financial metric used as a condition for the additional $10 million of capital allocation in year 4 and additional $10M of capital allocation in year 5.

c) Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years

SMHS generated operating cash flow margin of 7.7%, 7.6% and 4.9% for FY13, FY14 and FY15, respectively. The Hospital generated standalone operating cash flow margins of 9.5%, 12.7% and 12.1% for FY13, FY14 and FY15, respectively.

d) If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.

As noted in the Transfer Agreement 4.01(b) and 4.01(c), respectively, $10M of additional capital commitment would be available in the 4th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 3rd year following the effective date and likewise, $10M of additional capital commitment would be available in the 5th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 4th year following the effective date. As an example, if the effective date of Saint Mary's joining Trinity Health/NE-RHM is 7/1/15, then if in the year ended 6/30/18 Saint Mary's and its controlled subsidiaries produce an operating cash flow margin of 8%, an additional $10M of capital will be allocated to Saint Mary's for the year ended 6/30/19.

e) Are there specific projects the additional funding will be used for?

There are currently none identified to date.

9. Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:

a) Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.

Yes, subject to approval by NE-RHM and/or Trinity Health. The projects have not yet been prioritized. That would happen after the transaction and in conjunction with the NE-RHM capital planning process.

b) What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?

Saint Mary's will continue to spend capital as needed for routine equipment replacement and routine facility upgrades. These routine expenditures are part of the $100M of capital commitment.

c) What are the specific facility upgrades that are needed for $22 million?

At this time, it is expected that Saint Mary's Hospital facility will require upgrades to its primary back-up generator, electrical power switching gear, along with planned replacements of two chillers and a series of area-specific air handling units. Additionally, three elevators are slated for replacement in addition to necessary nursing unit upgrades and modernization. Further, it is expected that the Holiday Inn will be demolished and replaced with an ambulatory pavilion.

d) What types of clinical equipment is going to be purchased for $18 million?

At this time, planned upgrades include two new fluoroscopy imaging units, a house-wide telemetry and patient monitoring upgrade, a real-time location tracking system for critical clinical equipment, operating room furnishing upgrades, upgraded breast imaging technology, and upgrades to support transition to single bed patient rooms.

e) Explain the clinically integrated network development expenditure of $5 million.

This is an estimate of certain IT costs to integrate providers for purposes of coordinating care management throughout our communities.

f) Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.

At this time, it is expected that the $10 million will be used to develop urgent care (and related services (e.g. diagnostic x-ray and lab draw) in the communities we serve. As an example, Saint Mary's has announced that it plans to build a new urgent care center, primary care office and physical therapy center in Naugatuck by 2017. Please see **Exhibit 29** for the announcement. Further, it is planned that a new pavilion ($25 million) may be developed on the hospital campus to provide ambulatory surgery (currently off campus) and other hospital services.

10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.

Trinity Health, NE-RHM and Saint Mary's are all committed to charity care consistent with their respective charitable missions and core values. Emergency medical care services are required to be provided to all patients who present to the emergency department, without regard to the patient's ability to pay. Trinity Health, NE-RHM and all RHMs provide financial support to medically indigent patients. Saint Mary's policies are consistent with both Trinity Health and the NE-RHM.

Trinity Health and its hospitals, including Saint Francis Hospital and Medical Center ("Saint Francis"), comply with the requirements of Internal Revenue Code Section 501(r) applicable to tax exempt hospitals. In FY 2016, additional requirements are effective and require hospitals to ensure their policies and procedures address items such as extraordinary collection efforts, notification requirements for presumptive eligibility, application periods and processing requirements, financial assistance documentation requirements and communication requirements (e.g., plain language).

Saint Mary's policy provided in the original CON at Exhibit S4 (page 696) is Saint Mary's current policy. In addition, Saint Francis current policy was provided in the original CON, Exhibit 20 page 494. No changes have been made to these policies since the original filing.

Once Saint Mary's joins NE-RHM, Saint Mary's staff will have access to the NE-RHM and the system office for advice and assistance in further implementing financial assistance opportunities for patients and ensuring compliance with these requirements.

11. Regarding the long term debt and the SMHS retirement plan, respond to the following:

a) Explain further the unfunded pension obligations including providing the current funded status of the plan.

The underfunded pension liability per the September 30, 2015 audited financial statements, which notes Saint Mary's estimated plan liabilities in excess of plan assets was $75.9M.

b) Explain future plans to address the debt obligations including the rates being

paid presently and the rates that would apply if the debt was refinanced.

There are no immediate plans to restructure Saint Mary's debt at closing. Additional analysis will be completed to determine if an intercompany loan will be used to pay-off or refinanced Saint Mary's current outstanding debt post-closing. Please reference response to Question 13 for the current debt rates.

12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?

Saint Mary's has not made any formal attempts to secure funding through bonds or loans from banking institutions for capital projects listed on page 82.

13. What attempts were made to restructure debt under the current management structure?

Saint Mary's refinanced its CHEFA debt in April 2015. Saint Mary's secured a $15 million bank loan and used approximately $5 million in debt service funds to call and extinguish the CHEFA Bonds. The Series E CHEFA Bonds ranged from 5-6% interest. The bank loan is for five years with $250k due in principal each month having an interest rate of LIBOR plus 110 basis points (approximately 1.5% total).

14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.

NE-RHM does not have a separate credit rating. The most recent credit ratings for Trinity Health are as follows:

- Moody's – Aa3, stable outlook, 12/21/15
- S&P – AA-, stable outlook, 12/23/15
- Fitch – AA, negative outlook, 12/30/15

15. Which entities are included in the NE-RHM financial worksheet data on page 441?

The entities included in the NE RHM are:
Saint Francis Care, Inc. (now known as Trinity Health- New England, Inc.)
Saint Francis Hospital and Medical Center, Inc. and Subsidiaries
Mount Sinai Rehabilitation Hospital
Saint Francis Hospital and Medical Center Foundation, Inc.
Saint Francis Medical Group, Inc. and Subsidiary
Asylum Hill Family Medicine, Inc.

16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:

a) List all hospitals THC has integrated into its system over the past three years.

Please see response in Question 16b below.

b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.

Trinity Health's most recent system-level merger with Catholic Health East leveraged the capabilities and expertise of both organizations. The resulting scope and scale has yielded more than $285 million of synergies since the Catholic Health East/Trinity Health consolidation in May 2013, with more than $25 million additional synergies planned through the fiscal year ended June 30, 2016. Actual and forecasted synergies are through initiatives such as renegotiating national vendor contracts, centralizing data center operations, combining our two insurance captives, reducing third party administrator fees, insourcing work related to compliance, internal audit and tax, and through growth and standardization initiatives. Trinity Health reported operating expenses of $13.9B in FY 2015, therefore realizing synergies savings of 1.8% of operating expenses.

Savings have also been realized in other significant Trinity Health acquisitions of local health systems and hospitals:

St. Joseph Health, Inc. ("SJH") is located in Syracuse New York– Effective date 7/1/15 – SJH has only been part of Trinity Health for a short period of time but over the last six months, SJH has realized approximately $4M of savings related to integrating SJH into Trinity Health insurance programs (combined brokers, reduction of duplicate administrative costs, etc.), reducing supply expense and lowering the cost of debt service. Additionally, joining the Trinity Health debt program has also created benefits such as less administrative burden related to debt financing for local SJH management and eliminating debt issuance timing risk (the risk of accessing the debt market in a high rate environment). This $4M savings as a percentage of SJH $700M of annual operating expense is 0.6%.

Saint Francis Care, Inc. (SFC) – Effective date 10/1/15 – SFC has only been part of Trinity Health for one quarter. See response to 18 below for some opportunities anticipated to be realized.

17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.

Since this proposed transaction is still in the pre-approval stage, the type of information and analysis that is able to be performed is limited and, therefore, prevents the organizations from getting into specifics with respect to future savings. The areas identified in original CON are those areas where Trinity Health hospitals have historically realized benefits post close. Based on historical savings achieved by other

health systems after joining Trinity Health (refer to response to #16 above), the organizations anticipate achieving a 1% reduction in consolidated SMHS operating expenses by year two post-close. As noted in the response to #18 below, Saint Francis expects to achieve similar savings once efforts are fully implemented.

18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.

Saint Francis has only been part of Trinity Health for one quarter and the identification of cost savings and other opportunities is ongoing. Based on initial analysis preformed to date, we anticipate starting to realize savings over the next eighteen months and the annual impact of these items is approximately:

- $4.0 million in annual savings relating to utilizing Trinity's group purchasing organization
- $2.0 million in software costs
- $760,000 interest expense
- $600,000 depreciation expense
- $300,000 in revenue cycle costs

Total annualized savings upon implementation of these efforts are $7,660,000, approximately 1% of Saint Francis operating expenses. Saint Francis also anticipates that it will save approximately $3.0 million in capital costs over the next two years due to better pricing under Trinity contracts. This reduced capital expense will result in a reduction in annual depreciation expense as noted above.

In addition to the above synergies, as of October 1, 2015, Saint Francis Hospital and Medical Center defeased $246 million in outstanding CHEFA bonds utilizing proceeds from an intercompany loan from Trinity Health. In addition, a fixed pay interest rate swap was transferred to Trinity Health. This transfer resulted in a $44 million reduction of Saint Francis' liability related to the interest rate swap, which strengthened Saint Francis' balance sheet by increasing its unrestricted net assets. Furthermore, the results of the debt refinancing with the intercompany loan, resulted in a reduction in interest expense as well as eliminated future interest rate risks.

19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?

Saint Mary's will benefit from being part of the broader NE-RHM and its contracts. Cost reductions from NE-RHM contracts are expected for items such as medical supplies, blood products, information technology and management contracts as a result of being part of a much larger healthcare system.

20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?

These amounts have not been included in the financial projections. Shared system office services include Revenue Excellence, Treasury, Human Resources, Supply Chain Management and Information Technology. These shared services are charged to Saint Mary's by the NE-RHM using an appropriate metric once an organization begins to access the benefits of these system departments. The NE-RHM will be charged for its share of these services and the NE-RHM will determine appropriate allocation, if any, to the entities within the RHM.

21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.

Physician partnerships are contributing reason for the proposal as Saint Mary's strives to grow its physician enterprise. Over the past year and a half, Saint Mary's has formed Valley Health Alliance, an accountable care organization that has recently started working on shared savings program with Medicare. In addition, the ACO has begun a program with Anthem for those patients that are employees of Saint Mary's. This type of physician partnership requires additional management, staffing, data analysis and clinical oversight; areas where Saint Mary's needs more support. This is especially true as the number of physician partners continues to grow and as the shared savings programs are implemented. Saint Mary's could use the additional resources offered by NE-RHM whose physician enterprise is more equipped to handle these physician partnerships.

22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?

Saint Francis Hospital and Medical Center (Saint Francis), which is part of the NE-RHM, provides market leading Cancer, Joint Replacement and Cardiology services. Saint Francis's Cancer program is affiliated with Yale New Haven Health's Smilow Cancer Hospital, a premier research and treatment cancer institute. This proposal will allow for Saint Mary's to have better access to ground breaking clinical trials, provide broader screening and diagnostic tools, access to additional treatment options, increased psychosocial support and improved pain management therapies. Along with the high quality Radiation Therapy provided by the Harold Leever Cancer Center, patients in the Greater Waterbury area will benefit from this proposal. Saint Francis's Connecticut Joint Replacement Institute ("CJRI") is nationally recognized as a pioneer in reducing costs, improving quality and improving the patient experience. Saint Mary's collaboration with Saint Francis at adopting these advanced techniques can only stand to improve the joint replacement care in the Greater Waterbury market. Saint Mary's will benefit from the collaboration with Saint Francis's Hoffman Heart Institute. With one of the largest heart bypass and cardiac catheterization programs in the region, along with the national recognition from both the American Heart Association and American College of Cardiology, Saint Mary's will be able to adopt many of the techniques that made the institute nationally recognized. Trinity Health, with its 86 hospitals, will also provide the potential to learn and adopt best practices from hospitals leading the nation in these three services.

23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.

Currently Saint Mary's utilizes the McKesson Paragon EHR. While an adequate industry EHR, the NE-RHM's EPIC EHR system more seamlessly integrates inpatient, ambulatory and physician electronic medical information.

24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."

Costs reduction will be obtained from adopting best practices such as those exhibited by Saint Francis's CJRI program. CJRI has been able to reduce complication rates, reduce hospital length of stays, reduce pain and allow for a quicker recovery time so that patients may return to full function sooner. As Saint Mary's collaborates with NE-RHM, processes can be streamlined and others may be enhanced. Some examples may include medical supply purchase processes, provider recruitment, clinical program enhancements, clinical service benchmarking, call coverage contracts and medical equipment purchasing. In no manner does an elimination of duplicative services refer to clinical programs, rather it refers to the operational management of these services.

The language on page 85 is associated with the Lean Management approach. NE-RHM employs this organizational efficiency and quality approach, most notably associated with the Toyota Production System Manufacturing to many of its processes. A key component of this Lean Management approach is to focus on standardization of work to eliminate duplicative steps and thereby eliminate waste. A similar process is associated at UTC's through its Ito University. Once Saint Mary's becomes part of NE-RHM, many of its clinical protocols will be compared to those used by the NE-RHM. NE-RHM will standardize the way care is delivered at each clinical service site where possible. (A sample project illustrates the kind of standardization and reducing variations in care initiative that Trinity Health would engage in as part of this synergy. Reducing the wastage and unnecessary use of blood products (such as blood transfusions) not only is a process and resource drain but also poses health risks to patients from unnecessary transfusions. Trinity Health has a standardized process and protocol around when and how to use blood products. Implementation of this protocol would result in improved care, less waste and better health of our patients.)

There are no plans to eliminate any clinical services at Saint Mary's as a result of this application. However, an efficiency analysis, as noted above, will be completed for each clinical area once Saint Mary's has joined Trinity Health-New England.

This effort is time consuming and different for each clinical service. No timeline has been established for this work and a plan and related timeline will not be developed until after SMHS is officially part of NE-RHM.

a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.

See the answer to Question 24 above.

b) Indicate what services will likely be eliminated.

See the answer to Question 24 above.

25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:

a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.

Other Deductions includes the net position of the Hospital Provider Tax offset by expected supplemental payments. At the time of our original assumptions, the State reduced all supplemental payments for SFY16. We assumed supplemental payments would resume in SFY 17, which is the 4th quarter of our FY16. Therefore, the estimated net tax position increased to $9.7M for FY16. We assumed no change in supplemental payment or hospital tax base in FY17-FY19.

b) Other Operating Revenue remains the same in FYs 2016 – 2019.

Other Operating Revenue assumptions include decreases in Meaningful Use from Medicare and Medicaid which is offset by increases in other areas such as Cafeteria, Rent, Child Care, Grants and Net Assets Released From Restriction.

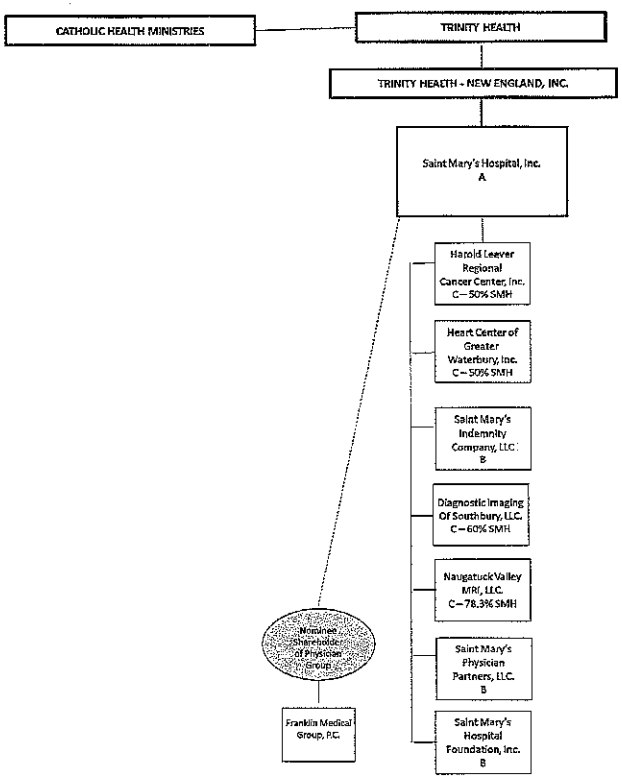
c) There are no self-pay revenues provided in any of the years.

See updated projections **Exhibit 30**. The net revenue by payor percentage was originally spread based on actual cash collections, however, bad debt expense should have been factored in, as the formula in the spread sheet is before bad debts. We note that self-pay net revenues are included in the uninsured category.

d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.

Saint Mary's refinanced its CHEFA debt in April 2015 saving approximately $1.0 million annually in interest costs. See response to Question 13 for further details.

EXHIBIT 24



A Direct Subsidiaries of THNE
B Direct Subsidiaries of A entities
C Shared entities – reflecting the ownership Percentages of SMH

EXHIBIT 25

Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Saint Mary's Hospital, Inc.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III

Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV

Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common

Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

ARTICLE VIII

Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with

such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

EXHIBIT 26

BYLAWS

OF

SAINT MARY'S HOSPITAL, INC.

A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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Article I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

(i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or

(ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

Article II. PURPOSES

Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

Article III. MEMBER

Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

Section 3.02 Member Authority

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the

Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

Section 3.03 Reserved Powers of Trinity Health

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

Section 3.04 Meetings of the Member

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

Article IV. BOARD OF DIRECTORS

Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation

(who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

Section 4.03 Term

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

Section 4.04 Annual Meeting of the Board of Directors

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

Section 4.05 Regular Meetings and Notice

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

Section 4.06 Special Meetings and Notice

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

Section 4.07 Waiver of Notice

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

Section 4.08 Quorum and Valid Director Action

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

Section 4.09 Written Consents

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

Section 4.10 Communication Equipment

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 4.11 Resignation

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

Section 4.12 Removal

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

Section 4.13 Periodic Performance Review

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

Article V. MEDICAL/DENTAL STAFF

Section 5.01 Medical/Dental Staff Bylaws

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

Section 5.02 Medical/Dental Staff of Operating Units

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

Article VI. COMMITTEES

Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective committees through the next annual meeting or until their successors are

appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

Section 6.04 Quorum, Meetings, Rules and Procedures

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

Section 6.05 Committee Composition

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

Article VII. OFFICERS

Section 7.01 Officers

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time. Officers shall hold their respective offices until their successors are chosen and qualified.

Section 7.02 Appointment and Election of Officers

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The Chair shall serve a term of one (1) year and may be elected for a total of three (3)

consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

Section 7.03 Vacancies

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

Section 7.04 Chair

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

Section 7.05 President

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

Section 7.06 Secretary

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

Section 7.07 Treasurer

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

Article VIII. INDEMNIFICATION AND STANDARD OF CARE

Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 8.04 Justifiable Reliance

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 8.05 Consideration of Factors

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 8.06 Presumption

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

Section 8.07 Personal Liability of Directors

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

Article IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

Article X. OPERATING UNITS

Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

Article XI. MISCELLANEOUS

Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

Section 11.03 Confidentiality

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

Section 11.04 Conflict of Interest

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

Article XII. AMENDMENT AND REVIEW

Section 12.01 Amendment

These Bylaws may be amended only in accordance with Article III of these Bylaws.

Section 12.02 Periodic Review

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

EXHIBIT 27

Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants: Connecticut Children's Medical Center
Saint Mary's Hospital Corporation
Waterbury Hospital

Docket Number: 07-31003-CON

Project Title: Termination of Inpatient Pediatric Services at Saint Mary's Hospital and Waterbury Hospital and the Establishment and Operation of New Inpatient Pediatric Services at Saint Mary's Hospital by Connecticut Children's Medical Center

Statutory Reference: Section 19a-638, C.G.S.

Filing Date: January 23, 2008

Hearing Date: February 20, 2008

Presiding Officer: Cristine A. Vogel, Commissioner

Decision Date: May 1, 2008

Default Date: May 22, 2008 (30-day extension)

Project Description: Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH") propose to terminate inpatient pediatric services and Connecticut Children's Medical Center ("CCMC") proposes to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility at an estimated total capital expenditure of $600,079.

Nature of Proceedings: On January 23, 2008, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH"), proposing to terminate inpatient

pediatric services, and Connecticut Children's Medical Center ("CCMC"), proposing to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility, at an estimated total capital expenditure of $600,079. CCMC, SMH and WH are health care facilities or institutions as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on February 20, 2008. On February 5, 2008, the Applicants were notified of the date, time, and place of the hearing. On February 2, 2008, a notice to the public announcing the hearing was published in *The Waterbury Republican-American.* Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact of the Proposal on the Applicants' Current Utilization Statistics
Proposal's Contribution to the Quality of Health Care Delivery in the Region
Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford, Connecticut. It is licensed at 103 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 19)*

2. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. It is licensed at 347 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 17)*

3. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. It is licensed at 357 beds and 36 bassinets. *(July 13, 2007, Letter of Intent, page 18)*

4. SMH and WH propose to terminate their inpatient pediatric services. CCMC proposes to establish, own, and operate new inpatient pediatric services within SMH. *(December 13, 2007, Initial CON Submission, page 2)*

5. CCMC will seek to have an additional satellite inpatient location, with 12 additional licensed medical/surgical beds, added to its existing Children's Hospital license issued by the State of Connecticut Department of Public Health. *(December 13, 2007, Initial CON Submission, pages 8 and 10)*

6. The following towns are within the service area of SMH and WH and account for over 90% of the pediatric admissions of the two hospitals in FY 2005, 2006, and 2007:

Table 1: Towns within the Service Areas for SMH and WH

Beacon Falls	Bethlehem	Cheshire	Middlebury	Morris
Naugatuck	Prospect	Southbury	Thomaston	Waterbury
	Watertown	Woodbury	Wolcott	

(December 13, 2007, Initial CON Submission, page 2)

7. The population to be served includes the 56,746 children between birth and 18 years of age in the service area towns based upon the 2000 census; 24,252 of them reside in the city of Waterbury. *(December 13, 2007, Initial CON Submission, page 3)*

8. SMH currently staffs 209 of its 347 licensed beds, 12 are in the pediatric unit. WH currently staffs 265 of its 357 licensed beds, 10 are in the pediatric unit. *(December 13, 2007, Initial CON Submission, page 4)*

9. According to the Applicants, all pediatric inpatients will be admitted to the CCMC inpatient pediatric unit located within SMH. SMH and WH will no longer have pediatric inpatients as part of their patient volumes. The pediatric providers and support staff will be part of CCMC. CCMC pediatric medical and surgical specialists will be available for consultations as needed. *(December 13, 2007, Initial CON Submission, page 4)*

10. The following table reports the respective hospital's market share percentage for each town within the service area:

Table 2: Market Share Analysis by Town and Hospital

	Market Share Percentage by Hospital					
Town	**CCMC**	**SMH**	**WH**	**Yale-NH**	**Others**	**Town Total**
Beacon Falls	0.5%	13.0%	17.7%	11.1%	42.2%	100%
Bethlehem	0.0%	15.5%	56.0%	2.9%	74.4%	100%
Cheshire	0.8%	10.8%	6.8%	23.9%	42.4%	100%
Middlebury	0.7%	20.9%	53.9%	7.1%	82.7%	100%
Morris	0.2%	9.4%	24.5%	4.5%	38.5%	100%
Naugatuck	0.7%	33.5%	40.5%	6.1%	80.8%	100%
Prospect	1.3%	40.4%	34.8%	8.4%	84.9%	100%
Southbury	0.3%	8.0%	35.2%	4.5%	48.0%	100%
Thomaston	1.0%	16.9%	47.1%	3.7%	68.8%	100%
Waterbury	0.7%	45.5%	42.3%	3.8%	92.3%	100%
Watertown	0.9%	21.3%	62.8%	4.0%	89.0%	100%
Woodbury	1.1%	45.0%	29.8%	3.6%	79.5%	100%
Wolcott	0.6%	12.8%	47.6%	6.0%	66.9%	100%

Source: OHCA Hospital Inpatient Discharge Database FY 2007.

11. The units of service for the past three fiscal years by service area town for each hospital for children ages 0 to 18, excluding newborns, are reported in the following three tables:

Table 3a: Service Utilization by Fiscal Year for CCMC

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007***
Beacon Falls	2	5	1	2
Bethlehem	2	0	0	4
Cheshire	16	21	18	17
Middlebury	5	4	7	2
Morris	0	0	0	1
Naugatuck	28	31	17	30
Prospect	7	6	17	16
Southbury	5	6	10	5
Thomaston	9	8	9	6
Waterbury	108	119	96	126
Watertown	29	24	16	32
Woodbury	10	5	5	6
Wolcott	31	27	16	14
Total for Service Area	**252**	**256**	**212**	**261**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

Table 3b: Service Utilization by Fiscal Year for SMH

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007***
Beacon Falls	3	6	3	1
Bethlehem	1	2	1	1
Cheshire	5	6	4	10
Middlebury	11	11	8	8
Morris	1	3	0	0
Naugatuck	59	47	56	65
Prospect	23	13	6	22
Southbury	5	3	5	5
Thomaston	6	3	10	4
Waterbury	519	511	503	511
Watertown	30	28	21	35
Woodbury	8	7	4	11
Wolcott	20	24	21	36
Total for Service Area	**691**	**664**	**642**	**709**
Other Towns	33	53	48	-
Grand Total	**724**	**717**	**690**	**-**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

Table 3c: Service Utilization by Fiscal Year for WH

	Fiscal Year			
Town	**2004**	**2005**	**2006**	**2007**
Beacon Falls	4	2	3	4
Bethlehem	5	5	3	1
Cheshire	4	2	2	2
Middlebury	14	5	13	11
Morris	1	2	1	0
Naugatuck	64	62	42	42
Prospect	6	13	6	6
Southbury	12	4	8	6
Thomaston	15	24	9	10
Waterbury	284	265	237	226
Watertown	49	51	33	38
Woodbury	12	13	14	12
Wolcott	16	18	21	20
Total for Service Area	**486**	**466**	**392**	**378**
Other Towns	53	32	28	-
Grand Total	**539**	**498**	**420**	**-**

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

(December 13, 2007, Initial CON Submission, page 40)

12. The following table reports the number of children under age 18, excluding newborns, who were treated at the SMH emergency department ("ED") or the WH ED:

Table 4: Number of Children Treated in SMH ED and WH ED

Facility	Category	FY 2005	FY 2006	FY 2007
Saint Mary's Hospital	Treated and Discharged	15,098	15,881	15,855
	Treated and Admitted	586	554	575
	Total	15,684	16,435	16,430
Waterbury Hospital	Treated and Discharged	10,225	9,685	9,157
	Treated and Admitted	348	384	385
	Total	10,573	10,069	9,542

Source: ChimeData ED Data, FY 2005 to FY 2007

13. The following table reports the bed occupancy of the pediatric units at SMH and WH by bed days:

Table 5: Bed Occupancy by Hospital and Fiscal Year

	SMH			WH		
	Fiscal Year			Fiscal Year		
	2005	2006	2007*	2005	2006	2007*
Number of Pediatric Beds	12	12	12	10	10	10
Maximum Number of Bed Days per Year	4,380	4,380	4,380	3,650	3,650	3,650
Pediatric Discharges	717	690	741	498	420	491
Average Length of Stay	2	2	2	2	2	2
Number of Pediatric Bed Days	1,434	1,380	1,482	996	840	982
Bed Occupancy, %^	32.7%	31.5%	33.8%	27.3%	23.0%	26.9%

* Source of FY 2007 pediatric discharges: OHCA Hospital Inpatient Discharge Database.
^ (Pediatric bed days/Maximum number of bed days per year) * 100.
(January 23, 2008, Completeness Submission, page 2)

14. The following table reports the number of projected admissions at the proposed CCMC pediatric inpatient unit, and the projected number of total inpatient days:

Table 6: Projected Volume

	FY 2008 *	FY 2009	FY 2010
Admissions	276	1,100	1,133
Total Inpatient Days	550	2,200	2,266

*Last quarter of 2008 only.
Note: These calculations are based upon a moving average of total pediatric inpatient admissions at WH and SMH for FY 2005 to FY 2007. CCMC is projecting 3% growth in FY 2010. The projected average length of stay is 2.0 days, the weighted average current length of stay for WH and SMH.
(December 13, 2007, Initial CON Submission, page 4)

15. CCMC is proposing a 12-bed unit, based on the following factors:
    - 1,100 pediatric admissions with an average length of stay of 2.0 days;
    - An average daily census for SMH and WH of 6.03 patients;
    - An estimated peak of 10.6 patients and a low 4.5 patients; and
    - Seasonal variations and additional bed flexibility for patients who stay less than 24 hours and are not reported in the daily census.

    (January 23, 2008, Completeness Submission, pages 1 and 2)

16. CCMC currently meets the guidelines of the American Academy of Pediatrics Committee on Hospital Care for facilities and equipment and for staffing patterns for patient care and support personnel at its main campus in Hartford. CCMC plans to meet these guidelines at the new satellite unit in Waterbury. *(December 13, 2007, Initial CON Submission, page 4)*

17. The Memorandum of Understanding concerning pediatric care in the Waterbury area has the following provisions:
    - CCMC will create a single community-wide pediatric program;
    - CCMC will own, operate and supervise an inpatient pediatric medical/surgical services unit located on the campus of SMH;
    - CCMC shall contract for space, equipment and support services from SMH as needed;
    - Initial contract is for five years, with automatic five year renewals;
    - Termination of contract requires 12 months notification;
    - SMH and WH Emergency Departments will continue to treat children;
    - SMH and WH will continue to provide children's outpatient services; CCMC will provide clinical leadership and enhanced training opportunities for clinical staff at both SMH and WH; and
    - CCMC shall provide all services and operate its program in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

    (December 27, 2007, Memorandum of Understanding dated December 19, 2007)

18. Patients will be admitted to the new pediatric inpatient unit either by their community physician or from transfer from the SMH's ED or WH's ED. *(March 19, 2008, Response to Additional Late File Request, page 2)*

19. For pediatric patients who have received a disposition from WH that an inpatient admission is required, transportation to the admitting hospital will be by ambulance. No transportation will be provided by parents or guardians. *(March 19, 2008, Additional Late File Request Response, page 2)*

20. The attending physician at the referring hospital is responsible for "medical control" until the patient arrives at the receiving hospital. The ambulance company will be the responsible party until care is transferred to the staff of the receiving hospital. *(March 19, 2008, Additional Late File Request Response, page 2)*

21. In FY 2006, WH had 420 pediatric inpatients, of whom 340 (81%) were admitted through its ED. It is estimated that 324 will be the approximate number of patients that may be transported to SMH for admission to the CCMC pediatric inpatient unit. *(March 19, 2008, Additional Late File Request Response, page 3)*

22. The majority of patients at the CCMC pediatric inpatient unit will be admitted by physicians from the Waterbury community who elect to have CCMC privileges. CCMC medical staff will oversee the care provided at the proposed pediatric inpatient unit to assist the physicians of record in day-to-day care of those patients. CCMC medical staff will include a full time medical director and mid-level practitioners, a combination of APRNs and physician assistants who will work under the direct supervision of that physician. Specialists on the CCMC medical staff, members of the CCMC Faculty Practice Plan or other CCMC-associated practices will be available on a consultative basis, at the request of the attending physician. If a patient requires ongoing specialty care they will likely be initially

admitted to CCMC in Hartford or will be transferred to that facility. *(January 23, 2008, Completeness Submission, page 2 and February 20, 2008, Hearing Testimony of Leonard Banco)*

23. The proposal will enhance the ability to recruit and retain pediatric staff through the integration with the staff of a children's hospital. CCMC has infrastructure for the education and training of pediatric healthcare professionals, including nursing and medical professional and post-graduate education programs that will support the consolidated department in Waterbury. This proposal will provide increased opportunities for recruitment of staff with pediatric skills and maintenance of their competency, and will allow pediatric staff to rotate between secondary and tertiary environments of care to enhance clinical education and maintenance of skills. *(December 13, 2007, Initial CON Submission, pages 4, 8, &17 and February 20, 2008, Hearing Testimony of Robert Ritz)*

24. Surgeons are less likely to have privileges at both hospitals, rather admitting to one or the other most of the time. Surgical patients below the age of 18, mostly ortho-pedic or general surgery patients, comprise a small percentage of patients admitted to the pediatric inpatient units. *(December 13, 2007, Initial CON Submission, page 9)*

25. The following conditions are frequently the reasons for pediatric inpatient admissions to SMH and WH:
    - Appendectomy;
    - Bronchitis, asthma, pneumonia, or pleurisy;
    - Cellulitis;
    - Concussion;
    - Diabetes;
    - Digestive disorders;
    - Kidney and urinary tract infections; and
    - Nutritional and miscellaneous metabolic disorders.

    Source: OHCA Hospital Inpatient Discharge Database 2005 to 2007.

26. With respect to CCMC, most referrals from the proposal's service area have been made by community pediatricians or family practitioners to pediatric medical and surgical sub-specialists who then admit them to CCMC. Additionally, a smaller number of admissions have been the result of inter-hospital transfers made by WH and SMH to CCMC. *(December 13, 2007, Initial CON Submission, page 9)*

27. The transfer policy concerning patients that require admission from the WH ED to the CCMC pediatric inpatient unit at SMH or another in-patient facility includes the following provisions:
    - The ED physician at WH will contact the accepting inpatient physician and arrange a bed transfer upon agreement that the patient's condition is appropriate for the level of care;
    - WH ED nursing staff communicate the nursing report to the receiving inpatient nursing staff;
    - Standard transfer documents and copies of patient care documentation and diagnostic studies are sent with the patient or faxed to the inpatient unit;

- Arrangements are made by the WH ED for appropriate levels of ambulance transport services;
- WH ED will serve as medical control during the transfer;
- Patients will be brought directly to the CCMC unit via the SMH ED entrance;
- The patient's caregiver or family will be informed of transfer arrangements and if permissible may accompany patient in the ambulance.

(March 19, 2008, Additional Late File Request Response, Attachment 3)

28. Follow-up outpatient care for patients discharged from the CCMC pediatric inpatient unit will be arranged by the patient's attending physician of record or designee. *(January 23, 2008, Completeness Response, page 5)*

29. As part of the transfer and admission process from WH's ED, SMH's ED and private physicians' offices, all patients will be informed about the new CCMC pediatric inpatient unit. The general public will be informed about the unit through a communications plan including press releases, paid advertisements, the public web sites of all three hospitals, and external signage at the hospitals. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

30. The draft communications plan indicates that press releases and paid advertisements to the general public will communicate that the CCMC pediatric inpatient unit at SMH will provide services in accordance with the Ethical and Religious Directives for Catholic Health Care Services, and that patients who prefer to be treated in a non-denominational environment will be transferred to CCMC in Hartford or another facility as directed by their attending physician. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

31. CCMC and SMH will have a Master Service Agreement where, on an exclusive basis, all of CCMC's needs for services shall be provided by SMH. SMH will provide the following services to the CCMC pediatric inpatient unit:
    - Perioperative;
    - Imaging;
    - Diagnostic Laboratory;
    - Pharmacy;
    - Pulmonary and Respiratory Therapies;
    - Supplies, any and all without limitation; and
    - Rehabilitative.

    (March 19, 2008, Late File 1)

32. The lease between SMH and CCMC has a five year term with two successive renewal options of five years each. The lease includes, but is not limited to, the following services:
    - Maintenance and repair;
    - Security;
    - Laundry and housekeeping;
    - Telecommunications; and
    - Occupational and Social.

    (March 19, 2008, Late File 1)

33. The following table summarizes the changes in staffed, licensed, and pediatric inpatient beds for each of the three hospitals:

Table 7: Summary of Changes to Staffed, Licensed, and Pediatric Patient Beds

Hospital	Bed Description	Existing Licensed/ Staffed	Proposed Increase or (Decrease)	Proposed Licensed/ Staffed
CCMC	Total	135/127	12	147/139
	Pediatric Medical/Surgical	103/92	12	115/104
SMH	Total	347/209	3 staffed adult	347/200
	Pediatric Medical/Surgical	12	(12)*	0/0
WH	Total	357/246	0	357/246
	Pediatric Medical/Surgical	10	(10)**	0/0

*Existing 12-bed unit will become the new CCMC owned and operated pediatric unit; SMH will add 3 staffed adult medical/surgical beds.

**Existing 10-bed unit will be used for adult medical/surgical beds.

(December 13, 2007, Initial CON Submission, page 10 and January 23, 2008, Completeness Response, page 3)

34. Martin Gavin, President, CCMC, testified at the hearing that:
    - The strategic mission of CCMC since its inception in 1996 has been to bring the highest level of pediatric care to as many children as possible;
    - Two years ago local pediatricians approached SMH and WH to consider the consolidation of the two inpatient pediatric units into a single unit;
    - For the past two years leaders from CCMC and the two hospitals have met regularly to investigate the best means to deliver pediatric inpatient care; and
    - For children that come to Hartford and do not have insurance CCMC makes every attempt to enroll them in the HUSKY program.

    (February 20, 2008, Hearing Testimony of Martin Gavin)

35. Gerald Boisvert, the Chief Financial Office for CCMC, stated at the hearing, "If necessary, CCMC would absorb the cost of the ambulance ride from WH's ED to SMH to be admitted to the new satellite unit." *(February 20, 2008, Hearing Testimony Gerald Boisvert)*

36. Bob Ritz, President and CEO of SMH testified that:
    - The three organizations have considered how to improve the access and quality of inpatient pediatric services in the greater Waterbury community;
    - The proposal is unique as WH and SMH are looking for ways to consolidate services to eliminate costly overhead duplication to improve each hospital's the long-term financial outlook;
    - The proposal will provide opportunities for professionals to train and obtain clinical experiences; and
    - The proposal is responsive to the State of CT's request to look for ways to collaborate with WH.

    (February 20, 2008, Hearing Testimony of Bob Ritz)

37. John Tobin, CEO of WH, stated at the hearing that if the proposal were implemented and then terminated, SMH and WH would resume providing the services, perhaps by continuing the same unit under SMH rather than splitting it out to two units. *(February 20, 2008, Hearing Testimony of John Tobin)*

38. Sandra Roosa, SMH, testified that currently WH has more psychiatric services for children than SMH. SMH does receive children requiring psychiatric services in its ED. It is the hospitals' belief that parents will continue to utilize the ED at the hospital of their choice. *(February 20, 2008, Hearing Testimony of Sandra Roosa)*

39. Leonard Banco, MD, CCMC's consultant for the proposal, testified that:
    - The children currently being admitted to SMH and WH are the secondary level inpatients requiring treatment for conditions such as asthma, dehydration, and minor trauma;
    - Most of the patients requiring care by sub-specialists are no longer admitted to SMH or WH, but are generally cared for by CCMC or by Yale-New Haven Hospital. The referring physician and the admitting physician decide where a child needs to be admitted based on the level of expertise required or the severity of the condition and the care that the patient will need; and
    - The CARES[1] unit at CCMC will consider making the Waterbury area the site of its next location for a CARES model program to address the needs of children with psychiatric needs.

    (February 20, 2008, Hearing Testimony of Dr. Leonard Banco)

40. Steven Schneider, MD, testified for WH that Medicaid currently pays for ambulance transportation for patients. *(February 20, 2008, Hearing Testimony of Steven Schneider)*

[1] The CARES (Children and Adolescent Rapid Emergency Services) program is a short-term care unit located within Hartford Hospital's Institute of Living under collaboration with CCMC that provides care for children and adolescents who are in psychiatric crisis with intensive psychiatric assessment, stabilization, and case management in order to link the child to community services.

Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Applicants' Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

41. The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. The components of the capital expenditure are given in the following table:

Table 8: Major Cost Components/Total Capital Expenditure

Medical Equipment (Purchase)	$	$100,000
Non-Medical Equipment (Purchase)*		$100,079
Construction/Renovation		$400,000
Total Capital Expenditure	**$**	**$600,079**

* Includes items such as beds, cribs, carts, appliances, and other patient room furniture and equipment.
(December 13, 2007, Initial CON Submission, pages 12 and 14)

42. The renovation costs include the creation of more rooms with single beds, so that parents can room-in. The inpatient area will receive a complete finish renovation. The current floor, wall and ceiling materials at SMH are worn and dated, and require replacement. The proposed renovations will be undertaken primarily to create a pediatric-friendly environment that emulates the appearance of CCMC's main campus in Hartford and bring the facility up to CCMC infection control standards. *(December 13, 2007, Initial CON Submission, page 13)*

43. CCMC has set a target date of June 1, 2008 to obtain State of Connecticut Department of Public Health license and plans to begin operations in July 2008. *(December 13, 2007, Initial CON Submission, page 14)*

44. Financial stability will essentially be unchanged for SMH and WH. Both hospitals will no longer employ dedicated pediatric providers or support staff for their former inpatient pediatric units which will partially offset the loss of revenue. *(December 13, 2007, Initial CON Submission, pages 4 and 19)*

45. CCMC will be billing for the proposed services. CCMC will pay SMH for services provided under the Master Service Agreement. CCMC will add a new cost center, "Waterbury Med/Surg." *(December 13, 2007, Initial CON Submission, pages 10-11 and March 19, 2008, Late File 1)*

46. WH's cost center, "Pediatrics" #9100-00, will be terminated. SMH's cost centers, "Pediatrics" #3040 and "Sacred Heart 4" #3085 will be terminated. *(December 13, 2007, Initial CON Submission, pages 4 and 11)*

47. The incremental revenues, expenses, and gain or loss from operations projected for the next three years for each hospital are reported in the following three tables:

Table 9a: Projected Incremental Revenues, Expenses, and Gain from Operations for CCMC

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue	Non-Government	$ 778,465	$3,431,772	$3,894,919
	Medicaid	678,975	2,715,900	2,797,377
Total Net Patient Revenue		**1,457,440**	**6,147,672**	**6,692,296**
Operating Expenses (variable)	Salaries	374,969	1,499,874	1,567,369
	Professional	125,000	500,000	522,500
	Supplies and Drugs	247,665	990,659	1,015,425
	Bad Debts	33,866	142,851	155,506
	Other Oper. Expenses	3,000	412,000	412,300
Operating Expenses (fixed)	Depreciation	30,000	60,000	60,000
	Interest	0	0	0
	Lease	358,750	1,435,000	1,435,000
Total Operating Expense		1,173,249	5,040,384	5,168,100
Gain from Operations		**$ 284,191**	**$1,107,288**	**$1,524,196**
FTEs		**5**	**20**	**20**
Inpatient Days		**550**	**2,200**	**2,266**

* Applicants expect that unmet demand will utilize the new CCMC pediatric inpatient unit and be similar to the growth rate at CCMC-Hartford.

(March 19, 2008, Late File 3, Exhibit 1)

Table 9b: Projected Incremental Revenues, Expenses, and Loss from Operations for SMH

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue	Non-Government	$(312,000)	$(1,323,000)	$(1,146,000)
	Medicaid	(245,000)	(1,035,000)	(1,467,000)
Total Net Patient Revenue		**(557,000)**	**(2,358,000)**	**(2,612,000)**
Other Deductions		(242,000)	(926,000)	(1,036,000)
Other Operating Revenue		251,390	1,065,675	1,182,189
Revenue from Operations		**(63,610)**	**(366,325)**	**(393,811)**
Operating Expense (variable)	Salaries	(282,670)	(1,198,125)	(1,329,000)
	Supplies and Drugs	43,240	183,150	203,054
	Other Oper. Expenses	0	0	0
Operating Expense (fixed)	Depreciation	0	0	0
	Interest Expense	0	0	0
	Lease Expense	0	0	0
Total Operating Expense		**(239,430)**	**(1,014,975)**	**(1,125,946)**
Gain from Operations		**$ 233,640**	**$ 937,477**	**$ 732,135**
FTEs		**(4)**	**(16)**	**(16)**
Inpatient Discharges		**(163)**	**(650)**	**(700)**

(March 19, 2008, Late File 3, Exhibit 1)

Table 9c: Projected Incremental Revenues, Expenses, and Gain from Operations for WH

Category	Account	FY 2008	FY 2009	FY 2010
Net Patient Revenue*	Non-Government	$(122,535)	$ (505,687)	$ (521,231)
	Medicaid	(210,723)	(869,018)	(922,839)
Total Net Patient Revenue		**(333,258)**	**(1,374,705)**	**(1,444,070)**
Operating Expense (variable)	Salaries	(227,813)	(938,588)	(966,745)
	Professional	(100,000)	(400,000)	(400,000)
	Supplies and Drugs	(25,313)	(104,288)	(107,416)
	Other Oper. Expenses	-	-	-
Operating Expense (fixed)	Depreciation	-	-	-
	Interest	-	-	-
	Lease	-	-	-
Total Operating Expense		**(353,126)**	**(1,442,876)**	**(1,474,161)**
Gain from Operations		**$ 19,867**	**$ 68,170**	**$ 30,091**
FTEs		**(3)**	**(10)**	**(10)**
Inpatient Discharges		**(57)**	**(226)**	**(226)**

* Projections do not include the revenues and expenses for the additional 10 adult medical/surgical beds that will be staffed after the CCMC opens the pediatric inpatient unit at SMH; includes $7,000 for Emergency Department Revenues for each payer group in FY 2008 and $28,000 for each payer group in FY 2009 and 2010.

(March 19, 2008, Late File 3, Exhibit 1)

48. CCMC's projected payer mix for the current year and for the three projected years of the proposal, based on gross patient revenue, are reported in the following table:

Table 10: CCMC's Payer Mix

Payer	Payer Mix			
	FY 2007 Current	FY2008 Projected	FY 2009 Projected	FY 2010 Projected
Medicare	0.2%	0%	0%	0%
Medicaid* (includes other medical assistance and managed care)	41.4%	50%	50%	50%
CHAMPUS and TriCare	1.0%	0%	0%	0%
Commercial Insurers	55.8%	49%	49%	49%
Uninsured	1.6%	1%	1%	1%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity

(December 13, 2007, Initial CON Submission, pages 16 and 21-22)

49. The payer mixes for SMH and WH for the current year and for the total facility for the next three projected years are reported in the following tables:

Table 11a: SMH's Payer Mix

Payer	Payer Mix**			
	FY 2007 Current	**FY2008 Projected**	**FY 2009 Projected**	**FY 2010 Projected**
Medicare*	44.7%	45.0%	45.0%	45.0%
Medicaid* (includes other medical assistance)	14.2%	14.0%	14.0%	14.0%
CHAMPUS and TriCare	0.4%	0.4%	0.4%	0.4%
Commercial Insurers*	37.2%	37.0%	37.0%	37.0%
Uninsured	0.3%	0.3%	0.3%	0.3%
Workers Compensation	3.2%	3.3%	3.3%	3.3%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

(December 13, 2007, Initial CON Submission, page 17)

Table 11b: WH's Payer Mix

Payer	Payer Mix**			
	FY 2007 Current	**FY2008 Projected**	**FY 2009 Projected**	**FY 2010 Projected**
Medicare*	43.0%	43.0%	43.0%	43.0%
Medicaid* (includes other medical assistance)	11.0%	11.0%	11.0%	11.0%
CHAMPUS and TriCare	0.0%	0.0%	0.0%	0.0%
Commercial Insurers*	41.0%	41.0%	41.0%	41.0%
Uninsured	1.0%	1.0%	1.0%	1.0%
Workers Compensation	4.0%	4.0%	4.0%	4.0%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

(December 13, 2007, Initial CON Submission, page 16)

50. The following table reports the payer mix for the pediatric patients discharged from SMH and WH in 2007:

Table 12: Hospital Payer Mix for Pediatric Discharges in 2007

Payer	SMH	WH
Medicare	0%	0%
Medicaid	58.0%	46.5%
CHAMPUS and TriCare	0.3%	0.2%
Commercial Insurers	38.2%	50.0%
Self Pay	1.0%	3.3%
Other	2.5%	0%
Total Pediatric Discharges Payer Mix	**100%**	**100%**

Source: OHCA Hospital Inpatient Discharge Database 2007.

51. The proposal's rate for a semi-private room is $2,600. The average pediatric inpatient per diem reimbursement rates for each hospital are reported in the following table:

Table 13: Average Per Diem Rates for Pediatric Inpatient Services

Hospital	Average Per Diem Rates for Pediatric Inpatient Services	
	Government* ***(Medicare, Medicaid)***	***Non-government*** ***(Commercial, Self-pay, and Others)***
CCMC	$2,137	$2,963
SMH	$850	$1,725
WH	$820	$1,680

(December 13, 2007, Initial CON Submission, page 18 and January 23, 2008, Completeness Response, page 7)

52. There is no State Health Plan in existence at this time. *(December 10, 2007, Initial CON Submission, page 2)*

53. CCMC, SMH, and WH have adduced evidence that the proposal is consistent with their long-range plans. *(December 10, 2007, Initial CON Submission, page 2)*

54. CCMC, SMH, and WH have improved productivity and contained costs through energy conservation, the application of technology, group purchasing, and reengineering. SMH also implemented product standardization and pharmacy standardization, utilization and inventory control. *(December 10, 2007, Initial CON Submission, page 7)*

55. CCMC, SMH, and WH have no teaching or research responsibilities that would change as a result of the proposal. *(December 10, 2007, Initial CON Submission, page 8)*

56. CCMC's unique characteristic of its patient/physician mix is that it is the only freestanding hospital in the state devoted solely to the care of children. It has a full array of pediatric medical and surgical specialists, as well as nursing and ancillary support totally dedicated to the care of children. In addition, it has its own nursing and medical professional and post-graduate education programs that will support the new satellite unit. *(December 10, Initial CON Submission, page 8)*

57. CCMC has sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(December 10, 2007, Initial CON Submission, Attachment 4)*

58. CCMC's rates are sufficient to cover the proposed capital cost and operating costs. *(December 10, 2007, Initial CON Submission, page 13)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. The three hospitals (together, referred to as "Applicants") have presented a plan to collaborate and design a more efficient delivery system for the care of inpatient pediatric patients in the Waterbury area. Although this proposal includes the termination of pediatric inpatient services by WH and SMH, it proposes a 12-bed inpatient pediatric unit that will be located at the SMH facility but owned and operated by CCMC.

The CCMC satellite located at SMH will emulate the look and feel of CCMC's main campus in Hartford. Patients will be admitted to the unit through the emergency departments ("ED") at SMH and WH, or by community physicians from the Waterbury area who elect to have CCMC privileges. A full time medical director and midlevel practitioners will oversee the day-to-day clinical care of patients on with unit, with CCMC physician specialists available for consultation as needed. The attending physician will coordinate follow-up outpatient care for patients discharged from the CCMC inpatient pediatric unit. In the event that a patient requires ongoing specialty care, they will most likely be admitted or transferred to CCMC's main campus in Hartford.

This proposal is the first collaborative venture of this type between CCMC and other providers. The proposal addresses the apparent excess capacity that exists at both SMH and WH while at the same time strengthening the clinical programs and staff competencies through the proposed consolidation of services. SMH currently has 12 pediatric beds, and WH currently has 10 pediatric beds. The pediatric inpatient units at both hospitals have been at approximately 50% capacity during the three most recent fiscal years. The hospitals have a combined average daily census of 6 patients, with a peak of 11 beds and a low of 5 beds. Since it appears that there is excess capacity at both inpatient pediatric units, this proposal's reduction in combined beds from 22 to 12 appears to be reasonable.

OHCA is concerned about access to critical pediatric inpatient services during implementation of the proposal, particularly the transition period between the closing of WH inpatient pediatric unit and the opening of the CCMC inpatient pediatric unit. OHCA is also concerned about the transportation of patients from the WH ED to the CCMC pediatric inpatient unit. Currently WH admits approximately 400 pediatric patients via the ED annually, and it would be this volume of patients that may potentially need

ambulance transport to the CCMC pediatric inpatient unit. OHCA is concerned that additional charges may be incurred by families initially presenting at WH and requiring transfer to CCMC. OHCA questions the impact of these charges and of the ambulance transfer itself on patient satisfaction with the proposed service. Since the unit will be located at SMH, OHCA does not have the same concern with the ED patients at SMH, as they need only be admitted to the CCMC unit on the premises. OHCA is concerned, however, that the proposal may ultimately result in an influx of pediatric volume over time arriving at SMH ED, adding to an already "crowded" ED.

The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. CCMC projects incremental gains from operations with the proposal of $192,894, $742,112, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. SMH projects incremental gains from operations with the proposal of $233,640, $937,477, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. WH projects incremental gains from operations with the proposal of $26,373, $96,654, and $61,034 in fiscal years 2008, 2009, and 2011 respectively. WH's projections do not include any gains/losses from the conversion of 10 pediatric medical/surgical beds to 10 adult medical/surgical beds.

In conclusion, this proposal will improve the quality of and access to specialized pediatric services in the proposed service area through collaboration between hospitals. However OHCA requires that the Applicants address more fully the effects of the proposal and address potential issues related to access, transfer, the admitting process, and other related matters. This approach assures the public of a sound professional facility that will serve the needs of pediatric patients and their families in the greater Waterbury area.

Order

NOW, THEREFORE, the Office of Health Care Access ("OHCA") and Connecticut Children's Medical Center ("CCMC"), Saint Mary's Hospital ("SMH"), and Waterbury Hospital ("WH") (together referred to as "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate pediatric inpatient services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079.

1. The Applicants' request for a Certificate of Need regarding the proposal to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate inpatient pediatric services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079, is hereby approved.

2. CCMC is authorized by OHCA to increase its licensed bed capacity, from 135 licensed beds to 147 licensed beds, an addition of 12 beds. CCMC must also obtain authorization from the State of Connecticut Department of Public Health to increase its licensed bed capacity by 12 beds. These 12 beds can only be staffed and utilized at the new satellite location at SMH and cannot be staffed at any other facility unless CCMC files with OHCA appropriate documentation and receives OHCA approval.

3. SMH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC pediatric inpatient unit is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject SMH to civil penalties pursuant to Section 19a-653, C.G.S.

4. WH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject WH to civil penalties pursuant to Section 19a-653, C.G.S.

5. There is no authorized change in the number of licensed beds at SMH or WH.

6. No less than two weeks prior to start of operations, CCMC shall file with OHCA written notification of the date upon which CCMC will begin operation of the inpatient pediatric unit within SMH. OHCA must receive this notification and acknowledge receipt of such in writing, prior to SMH and WH terminating their inpatient pediatric services. In addition, CCMC is required to file a copy of its license obtained from the State of Connecticut Department of Public Health to operate the satellite inpatient pediatric services unit.

7. The Applicants will create a charitable pool fund to cover any out-of-pocket expenses that the patient's and/or the parent's or legal guardian's health insurer does not cover as related to the transportation from WH ED to the CCMC satellite unit at SMH. It is the Applicants' responsibility to ensure that the patient's parent or legal guardian is aware of this policy. CCMC will administer the charitable pool fund and provide OHCA with the appropriate documentation of its formation. CCMC will report the usage of such funds to OHCA at meetings as stipulated in Condition 15.

8. Patients transported from WH ED to CCMC pediatric inpatient unit shall be directly admitted to the pediatric inpatient unit and shall not be admitted to the SMH Emergency Department ("ED"). In the event this occurs, SMH must cover all expenses related to this second ED visit.

9. SMH and WH will continue to provide outpatient and ED services to children.

10. Should SMH and/or WH propose to recommence pediatric inpatient services, each hospital shall file with OHCA appropriate documentation, including either a Certificate of Need Determination Request or a Certificate of Need Letter of Intent.

11. Should the agreement among the Applicants established by the Memorandum of Understanding be terminated, CCMC must obtain CON authorization from OHCA before termination of its pediatric inpatient unit at SMH.

12. CCMC will work to ensure that all community pediatricians/family practitioners and surgeons who have provided care for children at either or both SMH and WH will elect to have active privileges at CCMC in order to admit patients to the pediatric inpatient unit. CCMC will also reach out to additional practitioners in the Waterbury area in an effort to include all potential pediatric providers.

13. It is the responsibility of CCMC to inform the public of the new pediatric inpatient unit at SMH and that its services will be provided in accordance with the Ethical and Religious Directives for Catholic Health Care Services ("ERD").

14. CCMC shall distribute a Patient Satisfaction Survey to each patient, parent, or legal guardian that has been provided services at the pediatric inpatient unit. The survey shall be able to segment patients originating from WH and SMH EDs and shall have questions that focus on topics that include, but are not limited to:
    - Transfer and transport issues;
    - Prior knowledge of CCMC being the hospital provider;
    - Knowledge of the staff regarding the new satellite unit;
    - Knowledge of the ERD;
    - Overall patient experience, quality; and
    - Any other relevant feedback.

    The results of this survey are most important at the inception of the program and will be required for only the first full twelve months of operations. OHCA requires

that CCMC provide quarterly aggregated results one month after the completion of a calendar quarter.

15. OHCA requires meetings between the Applicants and OHCA concerning the operation of the CCMC pediatric inpatient unit. The first meeting with OHCA shall occur approximately two weeks prior to commencement of the operations of the pediatric inpatient unit. It will be at the discretion of OHCA to determine the frequency and number of future meetings to be held and the information that must be submitted at each meeting. Unless otherwise notified in writing by OHCA the meetings will focus on operational issues or barriers of access to care, including, but not limited to, transfer, admitting process, and ED issues.

16. CCMC must post a toll-free telephone number for patients, parents or legal guardians to call if they have concerns or complaints concerning CCMC pediatric inpatients services at SMH.

17. The Applicants shall provide OHCA with a finalized copy of the Master Service Agreement and each schedule, exhibit, attachment, and addendum to the Agreement within 30 days of execution of the Master Service Agreement.

18. The authorization shall expire on April 30, 2010. Should the termination of existing pediatric inpatient services at SMH and WH and establishment of new satellite pediatric inpatient services with CCMC as the license holder and operator not be completed by that date and available to patients, the Applicants must seek further approval from OHCA to complete the project beyond that date.

19. The Applicants shall not exceed the approved capital expenditure of $600,079. In the event that the Applicants learn of potential cost increases or expect that the final project costs will exceed those approved, the Applicants shall file with OHCA a request for approval of the revised project budget.

20. OHCA and CCMC, SMH, and WH agree that this Agreed Settlement represents a final agreement between OHCA and CCMC, SMH, and WH with respect to this request. The signing of this Agreed Settement resolves all objections, claims and disputes, which may have been raised by the Applicants with regard to Docket Number: 07-31003-CON.

21. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Signed by Martin J. Gavin on April 30, 2008

Date

Duly Authorized Agent for
Connecticut Children's Medical Center

Signed by Michael Novak on April 30, 2008

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by Colleen Scott on May 1, 2008

Date

Duly Authorized Agent for
Waterbury Hospital

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on May 1, 2008.

Signed by Commissioner Vogel on May 1, 2008

_____
Date

_____
Cristine A. Vogel
Commissioner

EXHIBIT 28

Execution Copy

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties.**"

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01.**

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01.**

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06.**

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06.**

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02.**

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"**Certification of AFFAP**" has the meaning set forth in **Section 6.22(c).**

"**Church Plan**" has the meaning set forth in **Section 6.22(e).**

"**Closing**" has the meaning set forth in **Section 5.01.**

"**Closing Date**" has the meaning set forth in **Section 5.01.**

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01.**

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a).**

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04.**

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth in **Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**NE-RHM**" has the meaning set forth in the preamble.

"**NE-RHM Controlled Subsidiary**" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"**NE-RHM Providers**" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"**Trinity Health Controlled Subsidiary**" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"**Withdrawal Liability**" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date.**"

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

cant do: a, b, c, o, q
consent for: d, e h, i, k, m, m, p
notify: f, g, j, l

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c)**, and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15**(a) of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the **"Saint Mary's Insurance Policies"**); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09**(b) of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12.**

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) **"Confidential Information"** means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a **"Disclosing Party"**) or its Representatives to the other Party (a **"Recipient"**) and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term **"Confidential Information"** does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBIT 29

Waterbury Republican
October 27, 2015

Borough 'gateway' unveiled

Developer shares pictures of project plans for Parcel C

BY PAUL SINGLEY
REPUBLICAN-AMERICAN

NAUGATUCK — Borough officials were enthusiastic Monday when developer Rob Oris unveiled pictures of his much anticipated project on Parcel C downtown.

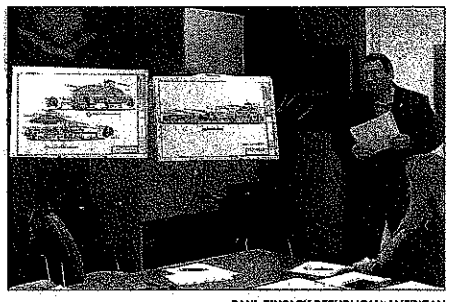
Oris, a veteran developer and Naugatuck native, showed architectural renderings for his proposal, which calls for a three-story, 30,000-square-foot medical office complex and a 5,000-square-foot retail/restaurant facility on the corner of Maple and Water streets.

"Our goal was to create a gateway to Naugatuck that we can all be really proud of," he said. "It's going to kick-start downtown revitalization."

Oris presented to the Naugatuck Economic Development Corp. and the Board of Mayor and Burgesses during separate meetings Monday night. Both boards unanimously approved the project. It will now go through the land use process. If approved, construction would begin in the spring.

The medical complex, which Oris believes will be a draw for people downtown, will be anchored by Saint Mary's Hospital of Waterbury. The first two floors will each be 11,000 square feet, while the third floor will be about 7,500 square feet, Oris said.

See **PARCEL**, *Page* **4B**



PAUL SINGLEY REPUBLICAN-AMERICAN

Developer Rob Oris shows renderings of his proposal for Parcel C in Naugatuck to borough officials Monday night.

PARCEL: Partners seek 'higher end' tenants

The buildings will face Maple Street and parking will be in the back. The renderings show a stucco material for the siding that is a mix of maroon and beige colors on the facade, a physical therapy fitness facility on the top floor and an outdoor seating area on the top floor.

There will be a courtyard in the front of the development with flower beds and a large flagpole. People will primarily enter the building from the back, where the parking lot is located.

Oris said the goal was to make the buildings look similar to the more appealing buildings in Naugatuck's downtown.

He said he is speaking with "an upscale coffee shop" to be a tenant in the smaller building, but stopped short of saying it is Starbucks.

The other tenant in the smaller building will be a bank. Both will have drive-thru windows.

Oris' partner, veteran developer John Lombard, said he thinks the traditional phrase of "if you build it, they will come" is not exactly what the developers were going for with this project.

"What's more important is who will come," Lombard said. "We're not out to attract a low-end tenant. We're trying to attract higher-end tenants.

"If we have that draw, what happens across the street (with future developments) is also going to feed off this," he said. "We're looking to bring in the best tenants, who are paying the most money and are successful over the long term."

Contact Paul Singley at psingley@rep-am.com, on Facebook at RA Naugatuck or on Twitter @RANaugatuck.

PAUL SINGLEY REPUBLICAN-AMERICAN

These are renderings of a developer's plans for Parcel C in downtown Naugatuck. The plans call for a medical office complex and a second building that will have both an 'upscale coffee maker' and a bank, both with drive-thru windows. Naugatuck officials approved the plans Monday night.

EXHIBIT 30

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$746,752	$786,099		$786,099	$825,404		$825,404	$866,674		$866,674	$910,008		$910,008
2	Less: Allowances	$484,798	$513,815		$513,815	$545,158		$545,158	$578,412		$578,412	$613,695		$613,695
3	Less: Charity Care	$1,854	$1,947		$1,947	$2,044		$2,044	$2,146		$2,146	$2,254		$2,254
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	$255,868	$260,591	$0	$260,591	$268,456	$0	$268,456	$276,370	$0	$276,370	$284,313	$0	$284,313
5	Medicare	$98,309	$100,067		$100,067	$103,087		$103,087	$106,126		$106,126	$109,176		$109,176
6	Medicaid	$47,555	$45,864		$45,864	$47,248		$47,248	$48,641		$48,641	$50,039		$50,039
7	CHAMPUS & TriCare	$199	$1,824		$1,824	$1,879		$1,879	$221		$221	$227		$227
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	$146,062	$147,755	$0	$147,755	$152,215	$0	$152,215	$154,988	$0	$154,988	$159,443	$0	$159,443
9	Commercial Insurers	$92,482	$95,376		$95,376	$98,255		$98,255	$101,151		$101,151	$104,058		$104,058
10	Uninsured	$8,522	$8,600		$8,600	$8,859		$8,859	$9,120		$9,120	$9,382		$9,382
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$7,785	$7,818		$7,818	$8,054		$8,054	$8,291		$8,291	$8,529		$8,529
13	Other	$1,017	$1,042		$1,042	$1,074		$1,074	$1,105		$1,105	$1,137		$1,137
	Total Non-Government	$109,806	$112,836	$0	$112,836	$116,242	$0	$116,242	$119,668	$0	$119,668	$123,107	$0	$123,107
	Net Patient Service Revenue (Government+Non-Government)	$255,868	$260,591	$0	$260,591	$268,456	$0	$268,456	$274,656	$0	$274,656	$282,550	$0	$282,550
14	Less: Provision for Bad Debts	$8,180	$8,512		$8,512	$8,938		$8,938	$9,384		$9,384	$9,854		$9,854
	Net Patient Service Revenue less provision for bad debts	$247,688	$252,079	$0	$252,079	$259,519	$0	$259,519	$266,985	$0	$266,985	$274,459	$0	$274,459
15	Other Operating Revenue	$7,473	$6,267		$6,267	$6,267		$6,267	$6,267		$6,267	$6,267		$6,267
17	Net Assets Released from Restrictions	$733	$700		$700	$700		$700	$700		$700	$700		$700
	TOTAL OPERATING REVENUE	$255,894	$259,046	$0	$259,046	$266,486	$0	$266,486	$273,952	$0	$273,952	$281,426	$0	$281,426
B.	OPERATING EXPENSES													
1	Salaries and Wages	$88,793	$93,086		$93,086	$95,413		$95,413	$97,798		$97,798	$100,243		$100,243
2	Fringe Benefits	$27,562	$25,721		$25,721	$26,364		$26,364	$27,023		$27,023	$27,699		$27,699
3	Physicians Fees	$10,621	$11,268		$11,268	$11,606		$11,606	$11,954		$11,954	$12,313		$12,313
4	Supplies and Drugs	$45,059	$44,320		$44,320	$46,536	($652)	$45,884	$48,863	($1,368)	$47,495	$51,306	($1,437)	$49,869
5	Depreciation and Amortization	$10,805	$11,116		$11,116	$11,449		$11,449	$11,793		$11,793	$12,147		$12,147
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$963	$216		$216	$205		$205	$195		$195	$185		$185
8	Malpractice Insurance Cost	$5,350	$5,094		$5,094	$5,196		$5,196	$5,300		$5,300	$5,406		$5,406
9	Lease Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$48,175		$48,175	$49,139	($708)	$48,431	$50,121	($1,403)	$48,718	$51,124	($1,431)	$49,692
	TOTAL OPERATING EXPENSES	$238,198	$238,996	$0	$238,996	$245,908	($1,359)	$244,549	$253,048	($2,772)	$250,276	$260,422	($2,868)	$257,554
	INCOME/(LOSS) FROM OPERATIONS	$17,696	$20,050	$0	$20,050	$20,577	$1,359	$21,936	$20,904	$2,772	$23,676	$21,004	$2,868	$23,872
	NON-OPERATING REVENUE	$3,158	$3,716		$3,716	$3,827		$3,827	$3,942		$3,942	$4,061		$4,061

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$20,854	$23,766	$0	$23,766	$24,405	$1,359	$25,764	$24,847	$2,772	$27,618	$25,041	$2,868	$27,932
	Principal Payments	$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000
7C	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	6.8%	7.6%	0.0%	7.6%	7.5%	0.0%	8.1%	7.5%	0.0%	8.5%	7.4%	0.0%	8.4%
2	Hospital Non Operating Margin	1.2%	1.2%	0.0%	1.2%	1.1%	0.0%	1.1%	1.1%	0.0%	1.1%	1.1%	0.0%	1.1%
3	Hospital Total Margin	8.1%	9.0%	0.0%	9.0%	9.0%	0.0%	9.5%	8.9%	0.0%	9.9%	8.8%	0.0%	9.8%
D.	FTEs	1,384	1,415		1,415	1,415		1,415	1,415		1,415	1,415		1,415
E.	VOLUME STATISTICS													
1	Inpatient Discharges	11,847	11,875		11,875	11,816		11,816	11,757		11,757	11,698		11,698
2	Outpatient Visits	238,522	246,611		246,611	251,543		251,543	256,574		256,574	261,706		261,706
	TOTAL VOLUME	250,369	258,486	0	258,486	263,359	0	263,359	268,331	0	268,331	273,404	0	273,404

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EBIDA	$29,464	$31,382	$31,382	$32,232	$33,591	$32,892	$35,664	$33,336	$36,204
	11.5%	12.1%	12.1%	12.1%	12.6%	12.0%	13.0%	11.8%	12.9%

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:		(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected
	Description		Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON
	Assumptions												
	Total Gross Patient Revenue	5.0%											
	Less: Allowances	6.1%											
	Less: Charity Care	5.0%											
	Less: Other Deductions	5.0%											
	Less: Provision for Bad Debts												
14	Less: Provision for Bad Debts	5.0%											
5	Net Patient Service Revenue less provision for bad debts												
15	Other Operating Revenue												
17	Net Assets Released from Restrictions												
	Salaries and Wages	2.5%											
	Fringe Benefits	2.5%											
	Physicians Fees	3.0%											
	Supplies and Drugs	5.0%											
	Depreciation and Amortization	3.0%											
	Provision for Bad Debts-Other[b]	2.0%											
	Interest Expense	-5.0%											
	Malpractice Insurance Cost	2.0%											
	Lease Expense	2.0%											
	Other Operating Expenses	2.0%											
	NON-OPERATING REVENUE	3%											
	Medicare		38.42%	38.4%			38.4%			38.4%			38.4%
	Medicaid		18.59%	17.6%			17.6%			17.6%			17.6%

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NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON
	Description											
	CHAMPUS & TriCare	0.08%	0.7%			0.7%			0.1%			0.1%
	Other	0.00%	0.0%									
	Total Government	0.00%	56.7%			56.7%			56.1%			56.1%
	Commercial Insurers	36.14%	36.6%			36.6%			36.6%			36.6%
	Uninsured	3.33%	3.3%			3.3%			3.3%			3.3%
	Self Pay	0.00%	0.0%			0.0%			0.0%			0.0%
	Workers Compensation	3.04%	3.0%			3.0%			3.0%			3.0%
	Other	0.40%	0.4%			0.4%			0.4%			0.4%
	Total Non-Government	0.00%	43.3%			43.3%			43.3%			43.3%
		0.00%	100.0%			100.0%			99.4%			99.4%

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$832,217	$873,828		$873,828	$917,519		$917,519	$963,395		$963,395	$1,011,565		$1,011,565
2	Less: Allowances	$535,300	$558,162		$558,162	$592,210		$592,210	$628,335		$628,335	$666,663		$666,663
3	Less: Charity Care	$1,854	$2,500		$2,500	$2,625		$2,625	$2,756		$2,756	$2,894		$2,894
4	Less: Other Deductions	$4,232	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746	$9,746		$9,746
	Net Patient Service Revenue	$290,831	$303,420	$0	$303,420	$312,938	$0	$312,938	$322,558	$0	$322,558	$332,262	$0	$332,262
5	Medicare	$111,743	$116,513		$116,513	$120,168		$120,168	$123,862		$123,862	$127,589		$127,589
6	Medicaid	$54,053	$53,402		$53,402	$55,077		$55,077	$56,770		$56,770	$58,478		$58,478
7	CHAMPUS & TriCare	$226	$2,124		$2,124	$2,191		$2,191	$2,258		$2,258	$2,326		$2,326
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	$166,021	$172,039	$0	$172,039	$177,436	$0	$177,436	$182,891	$0	$182,891	$188,392	$0	$188,392
9	Commercial Insurers	$105,120	$111,052		$111,052	$114,535		$114,535	$118,056		$118,056	$121,608		$121,608
10	Uninsured	$9,686	$10,013		$10,013	$10,327		$10,327	$10,644		$10,644	$10,965		$10,965
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,849	$9,103		$9,103	$9,388		$9,388	$9,677		$9,677	$9,968		$9,968
13	Other	$1,155	$1,214		$1,214	$1,252		$1,252	$1,290		$1,290	$1,329		$1,329
	Total Non-Government	$124,810	$131,381	$0	$131,381	$135,502	$0	$135,502	$139,668	$0	$139,668	$143,869	$0	$143,869
	Net Patient Service Revenue (Government+Non-Government)	$290,831	$303,420	$0	$303,420	$312,938	$0	$312,938	$322,558	$0	$322,558	$332,262	$0	$332,262
14	Less: Provision for Bad Debts	$9,675	$9,990		$9,990	$10,490		$10,490	$11,014		$11,014	$11,565		$11,565
	Net Patient Service Revenue less provision for bad debts	$281,156	$293,430	$0	$293,430	$302,449	$0	$302,449	$311,544	$0	$311,544	$320,697	$0	$320,697
15	Other Operating Revenue	$6,248	$7,253		$7,253	$7,253		$7,253	$7,253		$7,253	$7,253		$7,253
17	Net Assets Released from Restrictions	$733	$733		$733	$733		$733	$733		$733	$733		$733
	TOTAL OPERATING REVENUE	$290,137	$301,416	$0	$301,416	$310,435	$0	$310,435	$319,530	$0	$319,530	$328,683	$0	$328,683
B.	OPERATING EXPENSES													
1	Salaries and Wages	$123,041	$132,928		$132,928	$136,251		$136,251	$139,657		$139,657	$143,149		$143,149
2	Fringe Benefits	$32,244	$30,602		$30,602	$31,367		$31,367	$32,151		$32,151	$32,955		$32,955
3	Physicians Fees	$9,915	$11,031		$11,031	$11,362		$11,362	$11,703		$11,703	$12,054		$12,054
4	Supplies and Drugs	$47,026	$48,991		$48,991	$51,441	($720)	$50,720	$54,013	($1,512)	$52,500	$56,713	($1,588)	$55,125
5	Depreciation and Amortization	$11,502	$11,713		$11,713	$12,064		$12,064	$12,426		$12,426	$12,799		$12,799
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$979	$231		$231	$219		$219	$208		$208	$198		$198
8	Malpractice Insurance Cost	$5,572	$5,917		$5,917	$6,035		$6,035	$6,156		$6,156	$6,279		$6,279
9	Lease Expense				$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,631	$55,648		$55,648	$56,761	($817)	$55,944	$57,896	($1,621)	$56,275	$59,054	($1,654)	$57,401
	TOTAL OPERATING EXPENSES	$287,910	$297,061	$0	$297,061	$305,501	($1,538)	$303,963	$314,211	($3,133)	$311,078	$323,204	($3,241)	$319,960
	INCOME/(LOSS) FROM OPERATIONS	$2,227	$4,355	$0	$4,355	$4,934	$1,538	$6,472	$5,319	$3,133	$8,453	$5,482	$3,241	$8,723
	NON-OPERATING REVENUE	$2,190	$2,877		$2,877	$2,963		$2,963	$3,052		$3,052	$3,144		$3,144
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$4,417	$7,232	$0	$7,232	$7,897	$1,538	$9,435	$8,371	$3,133	$11,505	$8,625	$3,241	$11,867

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NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Principal Payments	$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000	$3,000		$3,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	0.8%	1.4%	0.0%	1.4%	1.8%	0.0%	1.8%	1.6%	0.0%	1.6%	1.7%	0.0%	1.7%
2	Hospital Non Operating Margin	0.7%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%	0.9%	0.0%	0.9%
3	Hospital Total Margin	1.5%	2.4%	0.0%	2.4%	2.8%	0.0%	2.8%	2.6%	0.0%	2.6%	2.6%	0.0%	2.6%
D.	FTEs	1,680	1,754		1,754	1,754		1,754	1,754		1,754	1,754		1,754
E.	VOLUME STATISTICS													
1	Inpatient Discharges	11,647	11,875		11,875	11,816		11,816	11,757		11,757	11,698		11,698
2	Outpatient Visits	238,522	246,611		246,611	251,543		251,543	256,574		256,574	261,706		261,706
	TOTAL VOLUME	250,169	258,486	0	258,486	263,359	0	263,359	268,331	0	268,331	273,404	0	273,404

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EBIDA	$14,708	$16,299	$16,299	$17,218	$18,755	$17,954	$21,087	$18,479	$21,720
	5.1%	5.4%	5.4%	5.5%	6.0%	5.6%	6.6%	5.6%	6.6%

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Assumptions													
	Total Gross Patient Revenue	5.0%												
	Less: Allowances	6.1%												
	Less: Charity Care	5.0%												
	Less: Other Deductions	5.0%												
	Less: Provision for Bad Debts													
14	Less: Provision for Bad Debts	5.0%												
	Net Patient Service Revenue less provision for bad debts													
15	Other Operating Revenue													
17	Net Assets Released from Restrictions													
	Salaries and Wages	2.5%												
	Fringe Benefits	2.5%												
	Physicians Fees	3.0%												
	Supplies and Drugs	5.0%												
	Depreciation and Amortization	3.0%												
	Provision for Bad Debts-Other[b]	2.0%												
	Interest Expense	-5.0%												
	Malpractice Insurance Cost	2.0%												
	Lease Expense	2.0%												
	Other Operating Expenses	2.0%												
	NON-OPERATING REVENUE	3%												
	Medicare	38%	38.4%			38%			38%			38%		
	Medicaid	19%	17.6%			18%			18%			18%		
	CHAMPUS & TriCare	0%	0.7%			1%			1%			1%		
	Other	0%	0.0%			0%			0%			0%		
	Total Government	0.0%	56.7%			57%			57%			57%		
	Commercial Insurers	36%	36.6%			37%			37%			37%		
	Uninsured	3%	3.3%			3%			3%			3%		
	Self Pay	0%	0.0%			0%			0%			0%		
	Workers Compensation	3%	3.0%			3%			3%			3%		
	Other	0.4%	0.4%			0%			0%			0%		
	Total Non-Government	0.0%	43.3%			43%			43%			43%		

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
		0.0%	100.0%			100%			100%			100%		

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, February 26, 2016 3:01 PM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: Completeness Letter 2: 15-32045-CON
Attachments: 15-32045 Completeness Letter Two 2.26.16 FINAL.docx

Dear Mr. Hartley and Mr. Anthony:

Attached please find a second completeness letter for Trinity and Saint Mary's CON application (docket number 15-32045). Instructions for responding are included in the body of the attached letter. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact us. Have a good weekend.

Jessica Schaeffer-Helmecki
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

February 26, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: **Completeness Questions, Docket Number: 15-32045-CON**
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

On January 29, 2016, OHCA received responses from the Applicant to OHCA's completeness questions. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a- 639a(c) and requests additional information.

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than **April 26, 2016**, otherwise your application will be automatically considered withdrawn.

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

1. With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?

2. Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?

3. Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:

    a) Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?

    b) If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?

    c) Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?

    d) Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?

4. For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:

    a) Chelsea Community Hospital
    b) Mercy Health Systems
    c) St. Alphonsus Regional Medical Center
    d) Loyola University Health System
    e) Catholic Health East

f) St. Joseph Health, Inc.

5. Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:

   a) St. Alphonsus Regional Medical Center
   b) St. Francis Hospital and Medical Center
   c) Johnson Memorial Hospital
   d) St. Joseph Health, Inc.
   e) Loyola University Health Systems
   f) Mercy Health Systems

Please email your responses to all of the following email addresses: OHCA@ct.gov, OHCA@ct.gov, jessica.schaeffer-helmecki@ct.gov, kaila.riggott@ct.gov; david.fernandes@ct.gov; ron.ciesones@ct.gov.

If you have any questions concerning this letter, please feel free to contact us.

Sincerely,

Ron Ciesones
Health Care Analyst
Ron.Ciesones@ct.gov
(860) 418-7030

Jessica Schaeffer-Helmecki
Planning Analyst
Jessica.Schaeffer-Helmecki@ct.gov
(860) 509-8075

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, February 26, 2016 3:41 PM
To: Greer, Leslie
Subject: FW: Completeness Letter 2: 15-32045-CON
Attachments: Read: Completeness Letter 2: 15-32045-CON

Read Receipt

-----Original Message-----
From: Hartley, Christopher [mailto:CHartley@stfranciscare.org]
Sent: Friday, February 26, 2016 3:04 PM
To: Schaeffer-Helmecki, Jessica
Subject: Read: Completeness Letter 2: 15-32045-CON

NOTICE: This email and/or attachments may contain confidential or proprietary information which may be legally privileged. It is intended only for the named recipient(s). If an addressing or transmission error has misdirected this email, please notify the author by replying to this message. If you are not the named recipient, you are not authorized to use, disclose, distribute, make copies or print this email, and should immediately delete it from your computer system. Saint Francis Care has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Care accepts no liability for any damage caused by any virus transmitted by this email.

Saint Mary's HOSPITAL

March 11, 2016

Via Email

Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find our responses to OHCA's February 26, 2016 letter regarding the above referenced Certificate of Need application. We are hopeful that these answers will allow us to move forward with Saint Mary's Hospital Inc.'s joining Trinity Health – New England, Inc. fka Saint Francis *Care* Inc.

As always should you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: Robert Anthony /af
Robert Anthony
General Counsel
Saint Mary's Health System

By: Chris Hartley
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.

Enclosures

1. **With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?**

   The amount Trinity Health currently charges to Regional Heath Ministries (RHMs) is 0.8% of operating expenses which was reduced over the last few years from 1% of operating expenses. Typically, organizations are not subject to this charge until one year after the transaction has occurred; however, the services are available immediately. This is the case for Saint Francis, Johnson Memorial Medical Center, and Saint Mary's. The allocation methodology is consistent for all similarly-situated RHMs. For example, the NE-RHM will be charged $8.9 million annually beginning 10/1/2016 for Saint Francis and its subsidiaries. As the NE-RHM continues to grow, the charge will increase based upon the incremental operating expenses of new organizations (e.g., Saint Mary's) within the NE-RHM. The NE-RHM would then be responsible for allocating the charge to its local hospitals and other subsidiaries. This charge is calculated annually and we would anticipate the allocation would decrease as we become more efficient through integration with the NE-RHM. This overhead allocation is to cover the costs associated with corporate functions that both strategically and operationally benefit all hospitals and RHMs and include but are not limited to the following:

   - Clinically Integrated Networks (CIN) group helps to position the organization to develop and support CINs in every market and to establish market position for the future delivery model under accountable care.

   - Provider Network Operations provides executive leadership to support the employed physician practices and drive consistent practices in operating models. There are over 3,900 employed physicians and this team works on strategic direction, synergies in the practices, productivity, and provides a standard for creating efficiencies and compensation and practice productivity models.

   - Clinical Resources group provides support and coordination of standard clinical practices and protocols, clinical analytics to evaluate and improve clinical scorecard indicators, Tiger teams to develop improvements, and clinical collaboratives for areas such as sepsis, falls, pressure ulcers, congestive heart failure, labor and delivery, etc.

   - Tax department is responsible for preparation and consulting for all federal, state and local tax compliance and is responsible for all in-house consulting and 990 and 1120 tax return preparation. The tax department is staffed by CPAs with extensive healthcare experience and provides support and coordination for any RHM under IRS or local tax audit.

   - External audit fees are included in the system allocation as the audit is performed on a

system-wide basis.

- The Organizational Integrity, Audit and Compliance department provides insourced services with strong compliance department talent, consistent compliance polices and education designed to support an effective compliance program. Organizational Integrity, Audit and Compliance strongly support RHMs on billing and coding. The internal audit department of CPAs supports local RHM management and governance to provide risk based internal audit assurance and also includes specialists in information technology internal audit.

- Legal Services provides insourced legal support for all corporate legal services including merger and acquisitions, joint ventures, physician contracts, contracting with vendors for non-labor and employee labor relations.

These system departments will reduce the amount of direct expenses Saint Mary's, Saint Francis, and Johnson Memorial Medical Center have incurred historically as many of these resources were outsourced to accounting, legal, and consulting firms.

2. **Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?**

   No, future acquisitions will not erode the capital available to Saint Mary's.

3. **Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:**

   a) **Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?**

      As noted on page 635 of the Saint Francis CON, "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development." The NE-RHM determined that Saint Mary's is an important element for its strategic growth and, as such, has determined a portion of the $275 million capital commitment to SFC will be allocated to Saint Mary's. SFC is in full support of this strategic investment.

b) **If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?**

If the 8% cash flow margin is achieved and Saint Mary's receives an additional $20 million of capital commitment, then it would be considered part of the $275 million of capital commitments made to SFC. Again, SFC believes Saint Mary's is an important strategic investment and has chosen to invest a portion of its capital in Saint Mary's.

c) **Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015 that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?**

Yes, as noted in 3 a) above, Trinity Health/NE-RHM had planned for capital expenditures committed for Saint Francis *Care* to be available for "strategic growth including potential mergers, acquisitions, joint ventures and physician network development." Of key importance to Saint Francis *Care* was joining Trinity Health to allow access to capital to support its goal of strategic growth and expansion within Connecticut and the region. Saint Mary's and Johnson Memorial represent such investments.

Please note, however, although Trinity Health/NE-RHM hoped both organizations referenced above would join its health system, there were both federal and state regulatory and legal approvals as well as independent Board approvals that had to occur before either organization could join NE-RHM.

d) **Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?**

No additional capital commitments have been made.

4. **For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:**

a) Chelsea Community Hospital
b) Mercy Health Systems

c) St. Alphonsus Regional Medical Center
d) Loyola University Health System
e) Catholic Health East
f) St. Joseph Health, Inc.

Overall, performance of these hospitals has benefitted from their affiliation with Trinity Health. Examples of specific savings that have been realized in these transactions are as follows:

- Chelsea Community Hospital, Chelsea, Michigan – Tangible benefits included:
    - Revenue growth of 40% between FY 2011 and FY 2016 driven by improved mix associated with surgery volume growth, practice acquisitions and outpatient growth.
    - Best practice outcomes in patient satisfaction, employee engagement and physician satisfaction.
    - Significant site capital investments based on its Master Facility Plan (e.g. new tower including conversion to private acute beds, expanding surgery and increasing ancillary and support space to backfill areas) have occurred totaling approximately $67M to improve environment of care and competitiveness.
    - Operating margin improved from 0.6% pre-merger to 4.4% currently
- Mercy Health, Hackley Campus – (Formerly Hackley Health System), Muskegon, Michigan - annual aggregate savings of $1 million, including from enhanced revenue management and reduced supply and vendor costs. Recently, Healthgrades announced hospitals that received Healthgrades 2016 America's Best Hospitals Award; Mercy Health – Hackley Campus received this award. Mercy Health – Hackley Campus reported an operating margin of -1.0% for the year ended June 2009, the first full year after they joined Trinity Health. Operating margin has improved substantially since then and for the year ended June 2015, Mercy Health – Hackley Campus reported operating margin of 10%.
- Three hospitals owned by Catholic Health Initiatives (Mercy Medical Center, in Nampa, ID; Holy Rosary Medical Center, in Ontario, OR; and St. Elizabeth Health Services, in Baker City, OR) were combined with Trinity Health's

Regional Medical Center in Boise, Idaho to create a new Regional Health Ministry, St. Alphonsus, which resulted in:

- Stabilizing financial performance across the region and specifically at Nampa campus with Operating Cash Flow Margin currently at 16.3%, up from 6.4% in FY 11. Operating margin is also strong and is currently at 9.8%.

- Successfully implemented Cerner EMR system at all three campuses in FY 13.

- Over $225M in investments are planned for relocation of the Nampa campus, which was in need of significant improvements, to a new location that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction.

- Loyola University Health System, Maywood, Illinois - In the first year of joining Trinity Health, Loyola improved its operational performance by $44.5 million across support functions including insurance/risk management, organizational integrity, supply chain, treasury, information services and revenue cycle. Additionally, operating margin and operating cash flow margins have improved substantially over time from -1.4% and 4.0%, respectively, at the time of the transaction, to 1.2% and 6.5% in fiscal 2015.

Also, as noted on page 872 of Docket No: 15-32045-CON cost savings have been realized as a result of the system-level merger with Catholic Health East as well as the recent acquisition of St. Joseph Health located in Syracuse, New York.

Timing of realization of savings is different in all cases; however, Trinity Health focuses on planning for and realizing savings as soon as possible after acquisition. Once savings are realized in a given year, those savings typically continue into the future. Trinity Health and its Regional Health Ministry's continuously look for opportunities for improvement in performance, whether related to Trinity Health system initiatives or strategic initiatives in the local markets. The recent acquisitions and other Trinity Health hospitals continue to benefit from Trinity Health's strong financial position which is supported by Trinity Health's ability to maintain strong ratings for several years. Most recent ratings are:

Moody's – Aa3, stable outlook, 12/21/15, S&P – AA-, stable outlook, 12/23/15, Fitch – AA, negative outlook, 12/30/15.

Although significant positive operational and financial results are realized, these hospitals as well as local hospitals in Connecticut are continuously challenged with decreasing reimbursement from both government and commercial payors and declining volumes. These external factors make it even more critical for local hospitals to leverage some of the resources of a larger health system.

5. **Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:**

    a) St. Alphonsus Regional Medical Center
    b) St. Francis Hospital and Medical Center
    c) Johnson Memorial Hospital
    d) St. Joseph Health, Inc.
    e) Loyola University Health Systems
    f) Mercy Health Systems

Pricing changes are operational in nature and are made as part of ongoing business decisions and are not made as a result of Trinity Health acquisitions. None of these acquisitions were made in order to increase or decrease the price structure of the entity. For Saint Francis Hospital and Medical Center, Johnson Memorial Hospital, St. Joseph Health, Inc., Loyola University Health System and Mercy Health Muskegon - Hackley campus, which is part of Mercy Health, there were no changes in price structure resulting from the acquisition. St. Alphonsus Medical Center – Nampa (Nampa, ID), part of the St. Alphonsus Regional Health Ministry did increase prices by approximately 12% following its acquisition as prior to the acquisition Nampa prices had not been increased for four years.

Greer, Leslie

From: Fernandes, David
Sent: Wednesday, April 06, 2016 11:10 AM
To: chartley@stfrancis.org; banthony@stmh.org
Cc: Schaeffer-Helmecki, Jessica; Riggott, Kaila; Greer, Leslie; Ciesones, Ron
Subject: CON-32045 Deemed Complete
Attachments: 15-32045-CON Notification of Application Deemed Complete.docx

Dear Mr. Hartley and Mr. Anthony:

Please see the attached letter deeming complete the above reference application. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

Thanks,

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 6, 2016

Via Email Only

chartley@stfrancis.org
Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

banthony@stmh.org
Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of April 5, 2016.

If you have any questions concerning this letter, please feel free to contact either me at (860) 418-7032, Jessica Schaeffer-Helmecki at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

David Fernandes

David Fernandes
Planning Analyst (CCT)

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Greer, Leslie
Sent: Monday, April 18, 2016 4:19 PM
To: 'chartley@stfranciscare.org'; 'BAnthony@Stmh.org'
Cc: Fernandes, David; Schaeffer-Helmecki, Jessica; Ciesones, Ron
Subject: Saint Mary's Health System, Inc. and Trinity Health, Inc. Hearing Notice
Attachments: 32045_201604181610.pdf

Mr. Hartley & Mr. Anthony,
Attached is the hearing notice for the Saint Mary's Health System, Inc. and Trinity Health, Inc. scheduled on May 9, 2016.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 18, 2016

Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

RE: Certificate of Need Application, Docket Number 15-32045-CON
Saint Mary's Health System, Inc., and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Dear Mr. Hartley,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Saint Mary's Health System Inc. and Trinity Health, Inc. ("Applicants") on April 5, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s): Saint Mary's Health System, Inc.
Trinity Health, Inc.

Docket Number: 15-32045-CON

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: May 9, 2016

Time: 3:00 p.m.

Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Republican American* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:DF:JSH:RC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 18, 2016 P.O. #54772

Republican American
389 Meadow Street
P.O. Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, April 20, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association
KRM:DF:JSH:RC;lmg

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Republican American
Notice of Public Hearing, Docket Number 15-32045-CON

April 18, 2016

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Saint Mary's Health System Inc. Trinity Health Inc.
Town:	Waterbury
Docket Number:	15-32045-CON
Proposal:	Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.
Date:	May 9, 2016
Time:	3:00 p.m.
Place:	Courtyard by Marriott Waterbury 63 Grand Street Waterbury, CT 06702

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Monday, April 18, 2016 4:24 PM
To: Greer, Leslie
Subject: Re: DN: 15-32045-CON Hearing Notice

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 4:09 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Tuesday, April 19, 2016 4:57 PM
To: Greer, Leslie
Subject: FW: DN: 15-32045-CON Hearing Notice
Attachments: 15-32045 Republican American.docx

Good afternoon,

This notice is set to publish tomorrow.
$190.83

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Tue, 19 Apr 2016 09:27:42 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN: 15-32045-CON Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 5:24 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: RE: DN: 15-32045-CON Hearing Notice

Attached is the word version.

From: ADS [mailto:ADS@graystoneadv.com]
Sent: Monday, April 18, 2016 4:30 PM
To: Greer, Leslie
Subject: Re: DN: 15-32045-CON Hearing Notice

Good day,

Thank you for your ad request.

We can not pull the text off of the attachment, please re-send asap.

Thank you
Graystone Group Advertising

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Monday, April 18, 2016 at 4:09 PM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Real Estate For Rent

Apartments
Condos
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Suburban
Vacation
Wanted to rent

Apartments for rent

APTS FOR RENT-WATERBURY
SECTION 8 WELCOME
2-3 BR, BEACON ST
3 BR, 19 TAYLOR ST
3 BR, 131 OAK ST
Se habla espanol
JOEL ROSARIO, Owner/Broker
Call Today 203-217-2593
A Home Connection R.E

NAUGATUCK 1 bedroom $725; Prospect Manor, lndry, storage, prkg, nice sec/ref. 203-753-3239

NAUGATUCK 3 BR, 6rms 1st floor 11 Maple Terrace, No pets. 1st, last, security. Call 203-725-5823

NAUGATUCK duplex 3 BR appl, W/D hkup, 2 baths, gar, no pets / smk $1200+sec 203-758-4327

OAKVILLE 1br 2nd flr, no smoke/no pets, H/HW elec., stove/fridge incl., close to Rte 8. $850+1 mo sec. **860-274-5841**

WATERBURY 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

WATERBURY 1, 2, 3, 4 BR Apts & Houses available **NEWLY RENOVATED** Agent 203-565-9639

WATERBURY 1, 2 & 3 rm apts clean, appl, util secure bldg lndry $465/up. Sect 8 OK. 203-753-3239

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY $1200 4 BR, brand new - just rebuilt. 1½ baths, convenient to I-84. **Velezis Realty, 203-574-7777.**

WATERBURY 174 Willow St. **studios, 1br** start @ $450 H/HW incl Sect 8 ok. 203-510-6177

WATERBURY **1BR, 2BR, 3BR** available starting @ $550. Section 8 accepted. 203-510-6177

WATERBURY 1BR & 2BR, No pets, on-site laundry. Starting at $650. Call 860-810-2941

WATERBURY 1BR *Must see, new!* Cabinets, appl, Priv, off st pk, no smk/pets $750 neg. 203 756 1140

WATERBURY 3 & 4 BR Chestnut Av WD hkups, remod, clean, no pets. Sec 8 $875 & up. 203-558-5142

WATERBURY 3 BR 199 Chestnut Ave., 3rd flr., large rooms, quiet, no pets, $750/mo. 203-722-7171

WATERBURY 3 BR, nice, HW floors, heat, parking & laundry included $800 (203) 206-4051

WATERBURY
5 RM/2 BR Town Plot - very spacious, hardwood floors. 1st floor **$850**, 2nd floor **$825**.
5RM/2 BR Town Plot - 1st flr, **$800**
4 RM/2 BR 1st and 2nd floor, 4-plex Town Plot, **$800**
OAKVILLE
6 RM/3 BR Raised Ranch - finished basement, 1 car garage. Sm. dog considered. **$1,500**
Farmingbury Real Estate
203-879-6491

WATERBURY 98 Rose St. **3**BR hardwood floors, gar., yard, $850+sec. Call 203-756-6339.

Apartments for rent

WATERBURY DOWNTOWN
Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $610; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

WATERBURY
EAST END APTS. some newly renovated, on busline, convenient to shopping, laundry on premises. $650-$675. Credit check. 203-725-6121

WATERBURY Giles St. 2BR, 1 bath, LR, DR, sunroom, gar. incl. gas heat, $890 No utils. 203-769-0898

WATERBURY Must see 1st flr. 2BR apt quiet dead end, W/D incl, Lg. inside porch, $750. 860 997 5468

WATERBURY spacious studio & 1BR & 2BR. $625, $750 & $850. Call for details 203-906-0817

WATERBURY STUDIO & 1 BR
41 Prospect St. Subsidized unit
Call Cristina 203-509-2025
Call Rose 203-560-9702

WATERBURY Town Plot 1st flr 2BR, appls incl, No pets. $875+2mos sec. 203-232-4693

WATERBURY **Town Plot** 2br $850. & **Hopeville** 2br $795. Call 203-729-2269, 203-805-1680

WATERBURY Town Plot 2BR, appl WD hkup, w/w, busline, no pets $850 cr ck sec 860-274-9554

WATERBURY Town Plot, 5RM 2nd floor, fresh paint, hdwd flrs. 649 Wilson St. No pets. 860-378-5877

WATERBURY Town Plot huge modern 8 rms, quiet nghbrhd, no pets, good ref. & cr. check $1100/mo. **914-906-5489**

Waterbury/Wolcott Line
Mod. elev. bldgs convenient well maintained **HILLTOP MANOR** Studios $570; 1 BR from $670; **LIBERTY COURT** heat, HW, elect. incl.; studios $650+; 1 BR $790+; Both incl. prkg., carpet/HW flrs, sec. & laundry. No pets. **Mgmt:** 203-755-0621; 203-470-9808

Condos for rent

WATERBURY 2BR Condo. W/D, $775 & up + sec. Sec 8 ok, No pets. 203-879-4126; 203-577-7516

Houses for rent

WATERBURY single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

Roommates

ROOMMATE WANTED clean, quiet, responsible, West Side of Naug. $900/mo. 860-830-5710,

Rooms

WATERBURY 27 Johnson St, furn room, mens rooming house, sec/clean bldg./ shared bath/ all util & cable inc/$125 wk & up, sec/ref chk req. 203.444.7252

Waterbury East End starting at $125 wk. Shared kit & bath, $400 sec. **Velezis Realty 203-574-7777**

WATERBURY furnished bedroom, $650/month. Utilities included. 203-753-3388

Rooms

WATERBURY FURNISHED ROOM non-smoking.
Call 203-524-6146

WOODBURY rooms for rent, no smoke, call George 203-266-4360

Real Estate For Sale

Houses

PROSPECT 176 Scott Rd to settle estate 3BR, 1.5 bath, garage, level lot, new roof & furnace. Easy access to 84. Low taxes, excel Schools. Asking $190,00. Call 203-233-0518 for Appointment.

Lots for sale

BANTAM LAKE (2) bldg lots on 5 ac priv. community. Tennis, boat, water & sewer incl. 860-868-1256

MIDDLEBURY LAND $87,000 or best, 20.49 acres, parcel ID 7-02-028, Benson Rd, **860-307-3695**

Mobile home

NAUGATUCK spacious 2 BR, 1.5 baths, newly remod. **$32,900** Liberty 860-747-6881 860-940-1204

PROSPECT new 2BR 2 bath easy access thru-out **$87,500** LIBERTY 860-747-6881; 203-592-7641

Commercial

Business for sale
Commercial for sale, lease, rent

Commercial for sale, lease, rent

WATERBURY medical office space 1200sf handicap access great location 203-206-4051

WATERTOWN Prime business location for Lease, two spaces from $750 and up, parking lot attached, Call Nico 203-206-3360

WOLCOTT Hair Salon/Barber Shop for Lease.
Excellent Location, turnkey operation, all equip. incl. Call John for more info 203-509-2939

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

HOT TUB 6 person w/outdoor circuit breaker & wire. Needs cover (approx $300); you haul away Wtby. 203-910-5947

STOVE (white) electric, works great. Call 860-274-0016 after 10:00am.

Lost & found

IMPOUNDED NAUG #112 m, pit bull beagle mix, brown & white Spring St 203-729-4324.

Lost & found

LOST CAT Young M Neut. Tabby, drk gray w/ light gray/tan markings. Lost near Lorann Dr. Naugatuck. 203-623-1318

Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

The Board of Finance and the Board of Councilmen of the City of Torrington will hold a Public Hearing on Monday, May 2, 2016 immediately following the Special Joint Meeting of the Board of Finance and the Board of Councilmen and the two previous public hearings that start at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the proposed 2016-2017 budget (except the school budget).

Copies of the proposed budget will be available at the office of the City Comptroller, and the City Clerk, prior to the hearing.

The public is invited to attend and to submit written or oral comments and questions on the budget.

Dated at Torrington, CT,
this 20th day of April, 2016.

BOARD OF FINANCE
BOARD OF COUNCILMEN
CITY OF TORRINGTON

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

The Planning and Zoning Commission has scheduled a public hearing on the following application on Wednesday, April 27, 2016 at 7:30 p.m. in the City Hall Council Chambers, Room 218, 140 Main Street, Torrington, CT:

a. Special Exception 16-305 and Site Plan 1178

Applicant: Greenstone, LLC
Location: 70 North Street
Proposal: Special Exception for storage of more than 100 cubic yards of earth materials; and site plan for vehicle parking and equipment storage outside of enclosed structure

A copy of the above mentioned proposal is on file in the Land Use Office, Room 324,
City of Torrington, 140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission

Dated in Torrington, CT
this 13th day of April 2016

R-A April 13 & 20, 2016

NOTICE TO CREDITORS
ESTATE OF Marian S. Mezzio, of Naugatuck, AKA Marian Mezzio, AKA Marion Mezzio, (16-00097)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Naugatuck Probate Court, by decree dated March 15, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Chief Clerk

The fiduciary is:
Richard Mezzio
c/o Atty James C. Winters
Winters & Winters
315 Highland Avenue, Suite 102
Cheshire, CT 06410

R-A April 20, 2016

Legals/ Public Notices

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

At its April 13, 2016 meeting, the Planning and Zoning Commission acted on the following applications:

a. Special Exception 16-307
Applicant: The McCall Foundation, Inc.
Location: 417 Prospect Street

Proposal: Group Care Facility, 7 – 12 beds
DECISION: Approved with conditions.

b. Location Approval and Site Plan 1183
Applicant:
CAO Enterprises LLC
Location: 2101 Winsted Road
Proposal: Repairer's license, Location Approval
DECISION: Approved

c. Special Exception 16-308
Applicant: Brian Butler
Location: 478 Norfolk Road
Proposal: Construct residential addition within front yard setback
DECISION: Approved with conditons

d. Zoning Regulations Amendment
Applicant: City of Torrington Planning and Zoning Commission
Proposal: Zoning Regulations, Amendments to Section 7.2, Flood Hazard Regulations

DECISION: Approved.
The effective date of the Zoning Regulation Change shall be April 21, 2016.

Copies of the above applications and plans are on file in the Land Use Office,
City of Torrington,
140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission
Dated in Torrington, CT
this 20th day of April, 2016
R-A April 20, 2016

READY FOR A NEW POSITION?

Check us out in print and online, you'll soon find there's opportunity in the Classifieds!
RepublicanAmerican

Legal Notice
Town of Winchester
Zoning Board of Appeals
Public Hearing

The Town of Winchester Zoning Board of Appeals will hold its meeting. A Public Hearing on April 26th, 2016, 7:00 p.m. in the P. Francis Hicks Room, 2nd floor Town Hall, 338 Main St., Winsted, CT to act on the following:

#16-5167 Request for variance from section 4.2 Frontyard Setback at 65 Oakdale Ave.

Interested parties may appear and be heard.
Dated this 11th day
of April 2016
David Villa, Chairman
Zoning Board of Appeals
R-A April 14 & 20, 2016

Legals/ Public Notices

LEGAL NOTICE
WARNING
ANNUAL TOWN BUDGET MEETING
TOWN OF WINCHESER, CONNECTICUT
Monday, May 2, 2016

Warning to all persons entitled to vote in Town Meetings of the Town of Winchester, County of Litchfield, and the State of Connecticut are hereby notified and warned that the Annual Budget Meeting of said Town will be held in The Gilbert High School Auditorium, 200 Williams Ave., in said Town, on Monday, May 2, 2016 at 7:00 p.m. for the following purpose to Wit:

1). To receive a report of the Board of Selectmen including its estimates of receipts and expenditures and its recommendation in accordance with the law and to take action upon the same and to adopt a budget for the Town for the next Fiscal Year commencing July 1, 2016

2). To take any action proper to come before said meeting.
Dated at Winchester, this April 19, 2016
Received by Sheila S. Sedlack, Town Clerk
RA April 20, 2016

Remodel It Right!
Find Help In The
At Your Service Directory
Every Day In The
RepublicanAmerican
Classifieds!

MOTHER'S DAY CONTEST

OFFICIAL CONTEST RULES

1. Submit your name, address and phone on an official entry blank. Entry form must be completely filled out. No photo copies will be accepted. All entries, dropped off or mailed, must be in a sealed envelope. Enter as often as you like. All entries will be eligible for the Grand Prize drawing.
2. Mail entries to: **MOTHER'S DAY CONTEST, P.O. Box 2000, Waterbury, CT 06722-2000.** Entries must bear proper postage. Only one entry per envelope. No payments or business correspondence should be mailed to this address.
3. No purchase necessary. Entry blanks published daily in the Republican-American *OR* are available at the Republican-American main office located at 389 Meadow Street, Waterbury.
4. All entries must be received by May 6, 2016. Grand prize drawing will be May 6, 2016. Winner will be notified by phone and winner's name will be published in the Republican-American on Sunday, May 10, 2015. Winner must appear in person during the hours of 9am and 5pm within seven business days *(Saturday and Sunday excluded)* from the date they are notified. The Grand Prize winner must be able to provide proper identification with the correct address as it appears on the official winning entry form.
5. Winner is responsible for applicable federal, state and local taxes.
6. Winner automatically permits the use of their name, address and photo for Republican-American promotional purposes.
7. Employees of the Republican-American, TeleReach, Inc. as well as their immediate families, are not eligible.
9. Participants must be 18 years of age or older.
10. Void where prohibited by law.
11. Odds of winning determined by the number of entries received.

Legals/ Public Notices

Notice of Permit Application
Municipality: Waterbury, CT

Notice is hereby given that F&G, LLC (the "applicant") of 15 Mullen Road, Enfield, CT is submitting, to the Department of Energy & Environmental Protection, an application under Connecticut General Statutes Section 22a-208a for a new permit for operation of solid waste facilities. The facility address is 260 Railroad Hill Street, Waterbury, CT.

The existing facility is currently permitted as a Single Item Recycling Facility for acceptance and processing of recyclable materials. The purpose of this new permit is to increase the processing capacity to 700 tons per day and to add the acceptance and transfer of municipal solid waste(MSW), the volume reduction of Construction & Demolition debris, over-sized MSW and non-putrescible MSW, and to accommodate the acceptance, processing and transfer of singlestream recyclable materials in addition of the previously permitted solid waste material (recyclable paper).

Once completed, interested persons may obtain copies of the application from Anchor Engineering Services, Inc, 41 Sequin Drive, Glastonbury, CT 06033, telephone (860) 633-8770, contact T.J. Therriault, at cost.

Once submitted, the application will be available for inspection at the Department of Energy & Environmental Protection, Waste Engineering & Enforcement Division, 79 Elm Street, Hartford, CT 06106-5127, telephone (860) 424-3366, from 8:30 to 4:30 Monday through Friday.

R-A 4/20/16

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
ORDER OF NOTICE

NOTICE TO: Kelli Smith; Mother of female children born on 10-11-07 and 9-14-12 and a male child born on 11-25-03 in town of Waterbury, CT

of parts unknown

A petition has been filed seeking:

Commitment of minor child(ren) of the above named or vesting of custody and care of said Child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.

Hearing on an Order of Temporary Custody will be heard on: 4-22-16 at 11:00 a.m. at SCJM, 7 Kendrick Ave, 3RD Floor, Waterbury, CT 06702.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Waterbury Republican American, a newspaper having a circulation in the town/city of Waterbury, CT

Honorable Joseph W. Doherty
Judge

Renee Polletta, Office Clerk
Date signed 4-15-16

RIGHT TO COUNSEL: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your Hearing is to be held.
R-A April 20, 2016

Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN, that the Board of Councilmen of the City of Torrington will hold a public hearing on Monday, May 2, 2016, immediately following the previous public hearing starting at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the lease of City of Torrington Property located at the Torrington Landfill, 105 Vista Drive in Torrington for the installation of a Solar Array Project. Sketches of the proposed project are available for public review in the City Clerk's Office.

All interested parties are invited to attend and be heard.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20 & 25, 2016

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the Board of Councilmen of the City of Torrington will hold a public hearing in the City Hall Auditorium, 140 Main Street, Torrington, CT, on Monday, May 2, 2016, at 6:30 p.m., with respect to the following proposed resolution:

Resolution Authorizing An Appropriation Of $4,100,000 For The East Basin Sewer Rehabilitation Project And The Financing of Said Appropriation By The Issuance Of Revenue Bonds, Notes And Obligations Of The City In An Amount Not To Exceed $4,100,000.

The full text of the proposed resolution is on file, and open to public in inspection, in the office of the City Clerk, 140 Main Street, Torrington, CT.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

Legals/ Public Notices

NOTICE OF WARNING OF DISTRICT MEETING

All electors and citizens who are qualified to vote in town meetings of the Towns of Bethlehem and Woodbury, Connecticut, are hereby notified and warned that a District Meeting of Regional School District 14 will be held in the library of Nonnewaug High School, 5 Minortown Road, Woodbury, Connecticut, on Monday, May 2, 2016 at 7:30 p.m.PURPOSE: TO CONSIDER THE BUDGET SUBMITTED BY THE BOARD OF EDUCATION FOR REGIONAL SCHOOL DISTRICT NO. 14 FOR THE FISCAL YEAR COMMENCING JULY 1, 2016 AND ENDING JUNE 30, 2017 IN THE AMOUNT OF $ 33,154,406.The vote on said budget will be by the voting machines in the towns of Bethlehem and Woodbury, Connecticut on Tuesday, May 3, 2016, between the hours of 6:00 a.m. and 8:00 p.m., the day following the District Meeting.
BOARD OF EDUCATION
REGIONAL SCHOOL DISTRICT NO. 14
Bethlehem and Woodbury, Connecticut
BY: George Bauer, Chairperson
RA 4/20/2016

TOWN OF LITCHFIELD
NOTICE OF PUBLIC HEARING OF THE BOARD OF FINANCE

The Board of Finance of the Town of Litchfield will hold a Public Hearing at the Litchfield Intermediate School Auditorium on Wednesday, April 27, 2016 at 7:00 p.m., at which itemized estimates of expenditures of the Town for the ensuing fiscal year shall be presented and at which all persons shall be heard in regard to any appropriation which they are desirous that the Board should recommend or reject.

Dated at Litchfield, Connecticut, this 11th day of April, 2016.

Helen RuwetBunnell
Anne Dranginis
Mitchell Fishman
Edward Gadomski
David W. Geiger
David W. Wilson

Board of Finance
Town of Litchfield
RA April 20, 2016

Office of Health Care Access Public Hearings

Statute Reference: 19a-638
Applicant(s): Saint Mary's Health System Inc.
Trinity Health Inc.
Town: Waterbury
Docket Number: 15-32045-CON
Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.
Date: May 9, 2016
Time: 3:00 p.m.
Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.
R-A April 20, 2016

NOTICE

Pursuant to General Statutes § 16-50p (a), the Connecticut Siting Council (Council) announces that, on April 14, 2016, the Council issued Findings of Fact, an Opinion, and a Decision and Order approving an application from The Connecticut Light & Power Company d/b/a Eversource Energy for a Certificate of Environmental Compatibility and Public Need for the Frost Bridge to Campville 115-kilovolt (kV) electric transmission line project that traverses the municipalities of Watertown, Thomaston, Litchfield, and Harwinton, which consists of (a) construction, maintenance and operation of a new 115-kV overhead electric transmission line entirely within existing Eversource right-of-way and associated facilities extending approximately 10.4 miles between Eversource's existing Frost Bridge Substation in the Town of Watertown and existing Campville Substation in the Town of Harwinton; (b) related modifications to Frost Bridge Substation and Campville Substation; and (c) reconfiguration of a 0.4 mile segment of two existing 115-kV electric transmission lines across the Naugatuck River in the Towns of Litchfield and Harwinton within the same existing right-of-way as the new 115-kV electric transmission line. This application record is available for public inspection in the Council's office, Ten Franklin Square, New Britain, Connecticut. 4/20/2016

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Henry's Appliance Repair We service all major brands & offer used appliances 203-632-8000

Asphalt paving

BRASS PAVING LLC ~ CT#575141 Paving driveways, sealing & repairs. Free est. 203-574-2693

MARINI PAVING 860-274-3978
* Driveways * Repairs
* Seal Coating * Drainage
#563045. 203-410-9226

SPINO'S PAVING
Comm'l and resid'l driveways, parking areas, plow damage repair and curbing replaced. Free estimates. Ct Lic #579761.
203-574-2547 cell 203-537-3151

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One call for all your pavement needs! Visit us online to learn the 7 secrets for choosing a paving contractor CT# 612743. Call 860-945-0873 Visit Deziel Paving on Facebook to view our current project.

Carpentry

DN Carpentry Window, doors, decks, baths, drywall, trim, paint, fin.bsmt. #614783, Ins. 203 233 0795

Electrical

Accurate Electrical
Fully insured, Lic. E1-189172
203-509-7027

DW ELECTRICAL Any size jobs, srvc grounding, upgrades, rem. Free est #182995. 203-592-3562

General services

EMT PROGRAMS Starting in May. For info call/email 203-632-9247 or mededstaff@mededct.com

Gutters

BAY KLEEN Gutter cleaning & repair, powerwashing homes & decks 203-525-3890. #0643703

PEET SEAMLESS GUTTERS & SERVICES
860-283-2292

Hauling services

ALL ABOUT SERVICE
S&P CARTING trash & cleanup 10-40 yard roll off containers. Same day svc. Ins V/MC **203-755-4656**

JAY & EDDIE
Junk removal & Lawncare.
Call 203-558-0488

JUNK REMOVAL furn., appliances, shed, attic, basement, piano removal, Spring cleanup, 20% off, 203-535-9817, 860-575-8218

Home improvement

BUDGET PAINTING & Remod roofs, siding & painting, fully insured #0638113. Call 203-982-5353

DREAM DECKS by Advance Contrsuction of CT 100% Financing, no money down 30 yrs exp. #0644836. 203-788-3799

PREMIER SERVICES kit bths decks ceramic tile siding roofing fully ins fr est lic. 641592. **203-228-3750**

Landscaping & lawns

ALL LAWNCARE
Spring has sprung. Spring cleaup, weekly lawn maint. All aspects of landscaping. Irrigation PLM0277997-P1. Fertlization program B2008. 203-755-4656

B&D LANDSCAPING landscaping, mowing, cleanups, trimming, com & res. #540877. Call 203-575-9282, 203-437-1641

BUD'S LAWN CARE cleanups, mowing, pruning, etc. FR. EST. Lic. #0645023; 203-558-9503

CREST LAWN SERVICES
mowing, and more. Reas. rates. Veteran. 203-509-6395

DB LANDSCAPE Lawn mowing Commr'l & Residential, mulching, trimming, stone work, free estimate, #0633401; 203-704-1640

SCREENED LOAM DARK, RICH FARM LOAM. PICKED UP OR DELIVERED. **203-879-2731**

Landscaping & lawns

Spring Cleanups/Property Maint. Weekly cut. East Mtn., Prospect, Naugatuck areas. 203-232-6342

Masonry

A-1 JIMMY'S MASONRY #604550. Walls, brick/ blue stone, steps, sidewalks, repairs & more. Free est. 203-982-0145/860-628-0455

ALFRED MASONRY 30+yr exp. Pools, deck, stamp conc, patios, retain. walls, stucco Ins #565904. Free est. Call 860-274-7977

BELULI MASONRY
Stone walls, fireplaces; Any size job; 203-695-8177; #HIC0565123

EXCEPTIONAL MASONRY
Pavers, stonework, chimneys, waterproofing, repairs, free estimates 0638978. 860-922-8922

F&R Masonry Walls, Patios, steps, walks, chimney, repairs, etc. *Free Est.* #0637257 ins. **203-805-9114**

FINELINE MASONRY Stamped Concrete,Patios,Walkways,Stonewalls, #0640314; 860-378-5877

JIMMY MASONRY Masonry stone, brick, steps, sidewalks, stone walls etc. #0639219. 203-808-0816

KONSTANDING MASONRY Stone pavers, steps, Patios, Chimney, repairs & more. Call 203-528-8294

PAUL'S MASONRY
Stone, brick, block, walks, chimneys, patios, FP's, etc. free est. #624168. 203-706-9281

Moving

DON'S * MOVING
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PUBLIC NOTICE OF INTENTION NOT TO PREPARE AN ENVIRONMENTAL IMPACT EVALUATION

A. PROJECT IDENTIFICATION
Project Name: Town of Salisbury, Preliminary Engineering Report I/I and Biological Nutrient Removal Water Pollution Control Facilities

Project Location: Lakeville and Salisbury Village Sewered Areas, Salisbury WPCF located at the end of Walton Street in the Village of Lakeville

1. Project Description:

The Town of Salisbury is proposing sanitary sewer rehabilitation and WPCF improvements to address the excessive infiltration and inflow (I/I) entering the old sanitary sewers and manholes, and achieve phosphorus reductions in the treated effluent wastewater in order to meet current and future NPDES permit limits. The existing wastewater collection and treatment system provides sanitary sewer service to both the villages of Salisbury and Lakeville. Although the town has not experienced significant population growth, many of the existing sanitary sewers and manholes located in the Village of Lakeville, which date back to the early 1900's, continue to age considerably and the regulatory environment has changed with respect to phosphorus reductions. I/I has been identified as a significant problem primarily in the Lakeville Village area. It is anticipated that through this effort, the town will be able to reduce sources of excessive I/I through proposed sanitary sewer rehabilitation by means of cleaning and lining of older existing sanitary sewers and the restoration of sanitary manholes. The elimination of excessive I/I along with the proposed WPCF improvements will also further reduce phosphorus concentrations through the implementation of a chemical feed system that will achieve reductions in the total phosphorus concentrations in the treated effluent. Proposed upgrades will not result in a footprint expansion of the sewer lines or an increase in hydraulic capacity of the WPCF.

2. General Information:

The Commissioner of Energy and Environmental Protection is required to ensure that the requirements of the Connecticut Environmental Policy Act (Section 22a-1 of the Connecticut General Statues, CGS) have been met pursuant to CGS Section 22a-482 and regulations adopted thereunder. Based upon the limited nature of this project, and the environmental benefits to be realized, staff has recommended that preparation of an Environmental Impact Evaluation is not warranted.

In accordance with Sec. 22a-482-3(a)(4)(A) of the Regulations of Connecticut State Agencies, this notice of intent not to prepare an Environmental Impact Evaluation is being published. Interested persons who wish to submit comments and/or obtain more information, including inspection of supporting documentation may do so by contacting Max Fan, between the hours of 8:00 a.m. and 3:30 p.m., Monday through Friday at (860) 424-3670. Written comments will be accepted for 30 days from the publication date and should be sent to the attention of the above contact person, Bureau of Water Protection and Land Reuse, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106-5127.

/s/Betsey Wingfield, Bureau Chief
Bureau of Water Protection and Land Reuse
Dated: 4/19/2016
R-A April 20, 2016

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Friday, April 22, 2016 11:22 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
Subject: 15-32045-CON Request for Prefile Testimony
Attachments: 15-32045 Saint Mary Issues & Request for Pre-File.pdf

Dear Mr. Hartley and Mr. Anthony,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 63 Grand Street, Waterbury, CT. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

ISSUES

Office of Health Care Access Docket Number: 15-32045-CON

The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:

1. The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.

2. The development of a plan to adequately fund Saint Mary's pension liabilities.

3. The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.

4. Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.

5. Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.

Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:

1. Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.

2. Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.

3. Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)

4. The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany

fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.

5. Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.

Trinity Health New England – Affiliated Hospitals	Capital Commitment (current)	Capital Commitment If Saint Mary's attains 8% cash flow margin
Saint Mary's	$	$
Johnson Memorial	$	$
St. Francis Hospital	$	$
Total	$	$

6. For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:

Source of Funding	Saint Mary's	Johnson	St. Francis
Routine Capital Expenditures	$	$	$
Operating/Non-Operating Income	$	$	$
Capital Contribution-Trinity	$	$	$
Other	$	$	$

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Friday, April 22, 2016 11:41 AM
To: Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA; Rotavera, Liz; Joe Connolly (JConnolly@Stmh.org); Attorney Bob Anthony (BAnthony@Stmh.org)
Subject: RE: 15-32045-CON Request for Prefile Testimony

Thank you

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Friday, April 22, 2016 11:22 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
Subject: 15-32045-CON Request for Prefile Testimony

Dear Mr. Hartley and Mr. Anthony,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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User, OHCA

From: Schaeffer-Helmecki, Jessica
Sent: Wednesday, April 27, 2016 8:20 AM
To: Hartley, Christopher; 'banthony@stmh.org'
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: 15-32045-CON Order of Admin Notice
Attachments: 15-32045 Admin Notice.pdf

Good Morning Mr. Hartley and Mr. Anthony,

Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075 | F: (860) 418-7053 | E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

Docket No: 15-32045-CON

April 27, 2016

In re: Saint Mary's Health System and Trinity Health – New England, Inc.

ORDER REGARDING ADMINISTRATIVE NOTICE

The Office of Health Care Access, for purposes of analyzing and rendering a decision in the application filed under Docket Number 15-32045-CON, is hereby taking administrative notice of:

a) ***In re Saint Francis Care, Inc. and Trinity Health Corporation, Inc.***, Docket No. 15-31979-CON:
- Exhibit D, Completeness Responses, pp. 635-37
- Exhibit J, Prefiled Testimony, p. 789
- Exhibit M, Hearing Transcript, pp. 23-35, and

b) ***In re Johnson Memorial Medical Center and Trinity Health New England.***, Docket No. 15-32002-CON:
- Exhibit A, CON Application, pp. 24, 71
- Exhibit D, Completeness Responses, p. 1974

Kevin Hansted

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Connecticut Department of Public Health

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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Greer, Leslie

From: Attorney Bob Anthony <BAnthony@Stmh.org>
Sent: Wednesday, April 27, 2016 10:36 AM
To: Schaeffer-Helmecki, Jessica; Hartley, Christopher
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: RE: 15-32045-CON Order of Admin Notice

Thank you.

Bob Anthony

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Wednesday, April 27, 2016 8:20 AM
To: Hartley, Christopher; Attorney Bob Anthony
Cc: Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
Subject: 15-32045-CON Order of Admin Notice

Good Morning Mr. Hartley and Mr. Anthony,

Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
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Saint Mary's Health System Disclaimer:

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Saint Mary's
HOSPITAL

May 3, 2016

Via Email and Hand Delivery

Jessica Schaeffer – Helmecki, JD, MPA
Planning Analyst
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Responses to Interrogatories and Pre-File Testimonies for the Certificate of Need Application for Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer- Helmecki:

Enclosed please find our responses to OHCA's April 22, 2016 letter regarding the above-referenced Certificate of Need application in both pdf and word formats submitted via email and one copy hand delivered.

If you have any questions regarding this response, please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573 or Bob Anthony, General Counsel at 203-709-6447.

Sincerely,

By: _____
R. Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Saint Francis Hospital and Medical Center

By: _____
Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.

Enclosures

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 63 Grand Street, Waterbury, CT. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

Phone: (860) 418-7001 • Fax: (860) 418-7053
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

ISSUES

Office of Health Care Access Docket Number: 15-32045-CON

The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:

1. **The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.**

   As noted on page 865 of the application, Trinity Health and Trinity Health – New England, Inc. will commit to ensure the expenditure of up to $100 million in Capital Expenditures to support the operations and strategic initiatives of Saint Mary's Hospital and Saint Mary's controlled subsidiaries. While a significant portion of the Capital Expenditures are anticipated to be for facilities, equipment and information technology as discussed on page 869 of the application, a portion of this commitment may be available to support strategic growth and enhancement of healthcare services to better serve the community within the Waterbury area.

   In terms of the financial feasibility of the proposal, cash flow from operations for Saint Francis and its controlled subsidiaries was $33.6 million for the last 12 month ended March 31, 2016. In addition, Saint Mary's and its controlled subsidiaries had cash flow from operations for the same period of$11.8 million. Based the Saint Mary's financial projections noted in Financial Worksheet A, Saint Mary's and it's controlled subsidiaries are expected to have positive cash flow from operations (less annual debt service payments) of $13.3, $15.6 and $18.1 million for the years ended September 30, 2016, 2017 and 2018. Based on the projected cash flow margins for the two organizations, it is anticipated that a portion of the funding for the capital commitment will be available from operations and any shortfall will be available through the Trinity Health debt program through Trinity Health –New England, Inc. (refer to Table in question #6 below). Also, see list of sources of funding at page 866 question #7. Lastly, Trinity Health's strong credit rating as noted on page 871, question #14, will allow continued access to capital for strategic investments which are aligned with the strategic plan.

2. **The development of a plan to adequately fund Saint Mary's pension liabilities.**

   As noted on page 870 of the application, Saint Mary's pension plan is currently underfunded and its funding status as of September 30, 2015 was 48%. Trinity Health's funded status for its defined benefit plans was 85% as of June 30, 2015. As noted on page 83 of the original application, the applicants will develop a plan to ensure Saint Mary's ability to make annual pension payments to the plan beneficiaries.

3. The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.

In March 2015, Saint Mary's obtained a $15.0 million bank loan. The bank loan has a five year term with $250,000 principal due each month and corresponding interest at the current LIBOR rate plus 110 basis points. The loan matures in February 2020. Saint Mary's is required to comply with certain financial covenants including a debt service coverage ratio of 1:25. It is expected that Trinity Health and Trinity Health – New England, Inc. would refinance Saint Mary's external debt with an inter-company loan post-closing. This is advantageous to Saint Mary's as it would eliminate current required debt covenant compliance at the local level.

See **Exhibit A** attached for description of Trinity Health's intercompany loan program and the process for accessing funds.

4. Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.

As stated on Page 22 of the application, joining Trinity Health-New England, Inc. will assist Saint Mary's in addressing the various demands created by the 2010 Patient Protection and Affordable Care Act (PPACA) including:

- Identification and development of new models of providing care
- The increased cost associated with quality improvements
- Physician partnerships
- Clinical service redesign
- Electronic medical records development
- Strategic alignments to form an integrated organization
- Meeting the needs of aging infrastructure and addressing the health service needs of the Waterbury community as identified in the Community Needs Assessment (see pages 189-261).

New Models of Providing Care

As noted on Page 622 of the application ". . . Trinity Health is intently focused on the delivery of high value Triple Aim outcomes that improve the health of those it serves, reduce the per capita cost of delivery care, and improve the quality of care and satisfaction of our patients . . . "Trinity Health's people-centered 2020 strategy is focused on its population health journey to improve the health of its communities and the experience of care for patients. Trinity Health's strategy is to build a people-centered health system in which the people it serves are placed at the center of every behavior, action and decision in the Trinity Health system.

Ultimately, the patients and their families who use Saint Mary's Health System, Inc., including Saint Mary's Hospital, will be able to move among the Trinity Health New England, Inc.'s facilities using a single medical record and be treated by a group of physicians and other health professionals that use a common set of clinical protocols. The goal of Trinity Health-New England, Inc. is to meet the Triple Aim objectives for each person's care. The goal would be for Trinity-Health-New England, Inc. will sign contracts with insurance programs covering the cost of care of these patients that will be based on per capita payment structures that support using the best site for individual care delivery once they exist. Trinity Health's group purchasing power, access to needed capital and the overall credit strength of Trinity Health will support the necessary changes needed to implement these new models of care for all parts of Trinity Health-New England including Saint Mary's Hospital and Health System.

Increased Cost Associated with Quality Improvements

Pages 622-624 of the application describe Trinity Health's ". . . Unified Clinical Organization (UCO) which provides a data and evidenced-based infrastructure for clinicians across the Trinity Health system to advance a culture of safety and high reliability . . . " led by clinicians, the UCO has promoted a wide range of system wide safety initiatives (see Page 623) which will be incorporated by Saint Mary's clinicians in their future patient interactions.

Saint Mary's clinicians will also participate in Trinity Health sponsored clinical conferences that feature recognized industry leading professionals and focus on proven methods to reduce costs, improve safety and quality. Access to this type of quality enhancement system would be too costly for a single hospital or system to provide its clinical staff on a routine basis.

In addition, as noted on Pages 262-282 on the application, Trinity Health-New England, Inc. has formed a series of clinical service lines which have a proven track record of success in the areas of quality and service excellence. Saint Mary's Hospital and Health System will become a vital member of these service lines as part of Trinity Health-New England, Inc.

Physician Partnerships

First and foremost, physicians are attracted to organizations that place the care of the patient first and are dedicated to meeting the highest standards of health care delivery. The commitment to quality care for patients by both Trinity Health and Trinity Health-New England, Inc. has been described previously. Both organizations will also address the new era of risk/value based contracts represented by the changes initiated by the PPACA, while still supporting the long standing commitment of Saint Mary's to education of physicians and other allied health professionals, a critical need for a state with an aging group of health care providers to match the aging of its population.

Furthermore, the scale of both Trinity Health and Trinity Health-New England, Inc. provide a recruiting infrastructure for health professionals and access to clinical collaboration that is second to none in the region and the country as a whole.

Clinical Service Redesign

Though covered previously, both Trinity Health UCO and Trinity Health-New England, Inc.'s Institute for Primary Care Innovation demonstrates both organizations' commitment to encourage innovation and the development and application of the latest clinical techniques to the treatment of patients. The purpose of clinical service readiness is to provide the right care in the right place at the right time. The population based approach to care management supported by Trinity Health seeks to keep people healthy and use an outpatient based approach whenever appropriate for care delivery.

Strategic Alignments to Form an Integrated Organization

As stated on Page 20 of the application ". . . Trinity Health has created an internal development team, charged with growth and strategic positioning of the system. Two of Trinity Health's key growth initiatives aim to extend and strengthen the Catholic healthcare mission of the organization through alignment with other organizations and to expand the system footprint to create an integrated accountable care organization (ACO) in every one of its mandates . . . "

Saint Mary's believes entering into a partnership with Trinity Health-New England, Inc. will join its organization to a strong regional Catholic system that already had an ACO and an electronic medical record as well as an established affiliation relationship with substantial post-acute care group of providers. This approach will be duplicated in the Waterbury market.

Trinity Health has indicated its willingness to support the strategic capital investment required by Trinity Health-New England, Inc. to support the strategic alignment needs of Saint Mary's Hospital and Health

Meeting the Needs of an Aging Infrastructure and the Need to Provide the Health Services the Community of Waterbury Requires, as Reflected in the Community Needs Assessment.

Pages 21-22, 31, 47, 82, 869 & 870 of the application make reference to the need for facility improvements, acquisition of new and replacement equipment and the purchase of a new electronic medical record. There is a 5 year capital need identified that includes:

	$ in Millions
• Hospital facility upgrades - – Primary backup generators – Electric power switching gears – 2 chillers – 3 elevators and several air handling units	$30

– Nursing unit upgrades – Upgrades and renovations	
• Replacement of clinical equipment – – Operating room refurbishing – Upgraded breast imaging equipment – Private patient room conversion	$18
• Information technology upgrades and electronic health record	$12
• Urgent Care/ambulatory Care	$10
• Ambulatory pavilion on campus -	$25
• Clinically integrated network development	$5
Total	$100

These categories add up to $100 million. Once Saint Mary's Hospital & Health System becomes part of Trinity Health-New England, Inc., additional detail will be developed as part of the Trinity Health annual capital expenditure budget designed to address these capital needs. As identified on Page 867 projects in excess of $5 million and $25 million must be approved by Trinity Health before Saint Mary's can spend the funds. Both Trinity Health and Trinity Health-New England will bring corporate resources in purchasing, construction planning and design and the financing of individual projects as needed. The approved capital expenditures will be part of the $100 million capital planned for Saint Mary's. Capital projects from the approved capital list will be identified and implemented in each fiscal year over the 5 year period. In some cases, projects that require multiple years will be identified within each annual capital budget cycle.

For more details on capital commitment for Saint Mary's and the rest of Trinity Health-New England, please refer to Question #s 5 & 6 of this document. With regard to the Waterbury Community Needs Assessment please refer to the answer to Issue #5 of this document.

5. **Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.**

On pages 189-261 (Exhibit 6) of the CON application contains the Community Needs Assessment for Waterbury completed by the Greater Waterbury Health Improvement Partnership ("GWHIP").

This Plan outlines key health statistics for the Waterbury area and identifies the challenges to keeping the population healthy. Mental health and substance abuse, obesity and tobacco usage were ranked very high in this report, and were used as the basis for organizing the work groups of the partnership.

Saint Mary's continues to play an active role in the Greater Waterbury Health Improvement Partnership (GWHIP). We have funded activities of the partnership, and play an active role in the steering committee. In addition to the work plans contained in the original document, several areas of focus have been identified. These include:

- Establishing a committee focused on asthma, with the express purpose of coordinating the activities of existing community programs such as Putting on AIRS and Easy Breathing. The formation of this workgroup is in consistent with Saint Mary's participation in the Connecticut Hospital Association's Asthma initiative. According to their website, "The goals of CHA's Statewide Asthma Initiative are to improve access and appropriate care by partnering with the community; reduce asthma hospitalizations and ED visits; and significantly advance progress toward health equity for asthma care and outcomes by 2017." Saint Mary's is an active participant in these activities.
- Supporting the formation of a Community Care Team (CCT) as part of our focus on improving mental health and substance abuse services. The CCT is a model that has been successfully implemented in other cities throughout the state. The Waterbury program, as proposed, will be financially supported through GWHIP partners and will employ a coordinator to provide administrative support for various providers to actively case manage high-frequency emergency department patients.
- Maintaining our focus on obesity, with an emphasis on establishing Healthy Corner Stores. This initiative is focused on making healthy food options available in low-income neighborhoods that have been designated as "food deserts."
- Establish a marketing and communications workgroup to more effectively communicate the resources available within our community.

By becoming a member of Trinity Health – New England, Inc. Saint Mary's will be able to strengthen its already considerable commitment to community health and preventative care services. As stated in the CON, Trinity's "Healthy People 2020" initiative is in alignment with and compliments Saint Mary's current efforts in community health initiatives.

With regard to unmet health needs, Trinity Health has a national initiative known as the "Community Health and Well-Being" strategy that focuses on three major health goals:

Goal 1: Reduce the number of people who are uninsured in our communities.

Goal 2: Prioritize obesity prevention and tobacco control and;

Goal 3: Transform safety net care

These system wide goals have deliverables that are specific, measurable, attainable, relevant and time bonded and all Regional Health Ministries are participants in achieving these goals.

Goal 1 Objective - In partnership with community organizations each regional health ministry (RHM) will host or co-lead 10 enrollment activities targeted at reaching a total of 5% of the eligible population in the RHM's market.

In an effort to achieve this objective each RHM is an active participant in the annual open enrollment efforts of each State Health Exchange.

Goal 2 Objective – Develop a tobacco and obesity prevention portfolio

This portfolio is aimed at supporting healthy choices in RHM communities including tobacco free living, physical activity and healthy eating.

This support includes forming community coalitions and changing institutional policies where necessary to ensure greater support for healthy communities. One example of the steps being taken in this area include Trinity Health's national and state efforts to move the legal minimum age for cigarette purchases to 21 (Tobacco 21).

Goal 3 Objective- Seeks to improve the health of seniors 65 years and older who are dually eligible for Medicare and Medicaid

The dually eligible elderly represent some of the poorest and sickest individuals. Working with Trinity Health each RHM will develop best care practices and innovations aimed at encouraging alternate care models and/or risk contracting initiatives focused on this population. Whenever possible these initiatives will include external partners from the community.

To support this initiative all members of Trinity Health have access to Trinity Health's central office resources including:

- A Data Mart containing a large array of data from many sources addressing needs and services used by dually eligible elderly.
- Summary of promising best practices for clinical integration.
- Turn key delivery tool kits.

Clearly by becoming a part of Trinity Health - New England Inc., a great deal of additional resources will be available to Saint Mary's in its efforts to improve health of the Waterbury community.

In addition to these Trinity Health system wide initiatives Saint Mary' s will also be integrated with the health needs strategies identified by Trinity Health – New England, Inc. through its own 2016 Community Needs Assessment (CHNA) and Strategic Implementation Plan (SIP). At present this CHNA is scheduled for completion on 6/30/16 and the SIP on 11/15/16. Once Saint Mary's Hospital and Health System joins Trinity Health - New England, Inc. its Data Haven survey

data will be reviewed and the priorities of the Trinity Health - New England, Inc. Strategic Implementation Plan will be adjusted to reflect this data where necessary.

Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:

1. **Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.**

   There is no distinction between Trinity Health-New England, Inc. (the formal legal name registered with the Connecticut Secretary of State) and the New England Regional Health Ministry (the abbreviated reference to the legal entity).

2. **Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.**

   See **Exhibit B** (note due to timing, YTD actual results were provided through March 31, 2016)

3. **Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)**

   See **Exhibit C** (note due to timing, YTD Financial Measurement Indicators were provided through March 31, 2016)

4. **The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.**

   As noted on page 1016 of the certificate of need application, the system office allocation is at the Regional Health Ministry level. Therefore, Trinity Health – New England will be charged these system office fees. Trinity Health – New England will then allocate the system fees to each organization within the regional health ministry based on at least two factors (size of the

organization and the status of utilization of system resources). The utilization of system office resources and further integration among the hospitals within Trinity Health – New England, Inc. should ultimately decrease local expenses. For example, if external audit and consulting firms are being utilized to prepare tax returns and other analysis, the system office resources including the tax department and internal consultants will be available to provide these services. Furthermore, as noted on page 1016, it is expected that the system office allocation will decrease as Trinity Health – New England, Inc. become more efficient through integration across the various hospital/systems.

5. **Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.**

Trinity Health New England – Affiliated Hospitals	Capital Commitment (current)	Capital Commitment If Saint Mary's attains 8% cash flow margin
Saint Mary's	$100 million	$120 million
Johnson Memorial	$ 13 million	$13 million
St. Francis Hospital	$162 million	$142 million
Total	$275 million	$275 million

As previously noted, this is the **minimum** capital commitment for each of the respective organizations and their affiliated entities. In addition, the allocation of the $275 million Capital Commitment as noted on page 1017 of the original CON and on page 635 of the Saint Francis CON will be based on strategic priorities of the collective organizations. "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development."

6. **For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:**

Source of Funding	Saint Mary's	Johnson	Saint. Francis
Total Capital Expenditures (Capital Commitment)	$100.0 million	$13.0 million	$162.0 million
Operating Income (Minimum from operations for capital is to fund annual deprecation)[1]	$45.3	$5.6	$158.0
Trinity Health (intercompany loan and/or capital contribution)	$54.7	$7.4	$ 4.0
Other	$n/a	$n/a	$n/a

As noted in the response to question #1 above, the goal of Trinity Health – New England is to fund the $275 million total Capital Commitment for the region through cash flow from operations. The preliminary budget for FY 2017 for the Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. Therefore, if such target is not achieved, the allocation necessary from Trinity Health may increase. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. The allocation by source of funding is preliminary based on current operating performance and could change based on future operating cash flows.

As noted in the response to question #1 above, the goal of each of the hospitals/systems is to fund the majority of the capital expenditure through current operations. The preliminary budget for FY 2017 for Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. Further allocation of the source of funding by category by entity for these respective five year commitments are not known at this time.

[1] Estimated based on current annual depreciation less principal debt payments

EXHIBIT A

Exhibit A

Trinity Health Inter-Company Loan Program (the "Program")

Program Description

Under the Program, Trinity Health is the primary obligor on all existing tax-exempt debt issued by Trinity Health or its predecessor organizations. All tax-exempt debt is issued by Trinity Health under the Trinity Health Master Trust Indenture. Long-term debt of Regional Health Ministries (RHMs) is coordinated by Trinity Health and funded internally through loans from the Program.

Background and Program Characteristics

- Ensures all RHMs borrow at the same rate
- Enables the financing of projects in states with the lowest all-in borrowing costs through composite bond issues, typically on an annual basis
- Maximizes the life of the debt and minimizes annual debt service requirements
- Proceeds from annual composite bond issues are used to replenish the Program fund
- Proceeds from Inter-Company Loans (ICLs) are used to:
    - Replenish cash spent on capital expenditures
    - Offset annual increase in operating expenses to maintain days cash on hand
    - Fund the amortization of debt

Process for Issuing Inter-Company Loans

Each year during the Strategic Financial Planning process, the appropriate amount of debt and cash for each RHM is determined. This is further refined during the annual Budget process.

- The total budgeted amount to be borrowed by each RHM is calendarized and System Office Treasury provides rate and monthly interest expense schedules to include in the budget
- Treasury will receive final approved budgets which will indicate, by RHM and month, the amount to be borrowed during the fiscal year
- Per the approved budget, Treasury initiates transfers to the respective RHM operating accounts on the first business day of each month

- Treasury initiates sweep transactions for interest, principal and swap charges each month

Standard Program Procedures

- Calculation of Program Effective Interest Rate (the "Sweep Rate") *
    - Forecast interest rates
        - Obtain LIBOR and SIFMA rates projection from independent third party sources
        - Determine external interest expense for total indebtedness
    - Determine cost of debt administration
        - External interest expense
        - Commercial Paper fees
        - Trustee, legal and finance authorities' service fees
        - Swap settlements
    - Set rates for budget period for interest and swap payments
        - The Sweep Rate will be assessed to each participant based on their total intercompany loan balance outstanding
- Periodic Adjustments to RHM Sweep Rate (if necessary)
    - Notice of rate change to RHMs
    - Analysis of impact to operating income and budget
    - Prepare updated amortization schedules
- New ICLs
    - Develop recommendation for proposed loan via budgeting process
    - Prepare loan documentation, including RHM Promissory Note
    - Coordinate and initiate loan(s) according to budget schedule on first day of each month
- Collection of ICL Debt Service
    - Distribute updated amortization schedules
    - Initiate mid-month cash sweep
    - Coordinate accounting records
- Impact of New Bond Issues
    - Incorporate new debt into Cost of Capital schedule
    - Calculate revised budget rates

**Includes Cost of Trinity Health Swap Program*

Debt Refinancing and Refunding

- In addition to the replenishment of Program funds, the annual composite bond issue also provides an opportunity to refund tax-exempt bonds
- Existing Trinity Health tax-exempt bonds are continuously monitored and analyzed to determine if there is sufficient economic benefit to refund
- In conjunction with the acquisition of a new affiliate, the entity typically enters into the Trinity Health Credit Group as a Designated Affiliate under the Trinity Health Master Trust Indenture
- To the extent allowable under existing documents, the debt of the new affiliate is defeased or redeemed through an Inter-Company Loan from the Program (the underlying bonds may be refunded through the annual composite issue or through the Trinity Health Commercial Paper Program as an interim/bridge financing until the next appropriate composite issue

EXHIBIT B

(YTD) actual results for
Saint Mary's Health System, Saint Mary's Hospital and
TH-NE

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2016 YTD March W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$832,217	$454,966		$454,966			$0	$0		$0	$0		$0
2	Less: Allowances	$535,300	$297,452		$297,452			$0	$0		$0	$0		$0
3	Less: Charity Care	$1,854	$855		$855			$0	$0		$0	$0		$0
4	Less: Other Deductions	$4,738	$6,348		$6,348			$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$290,325**	**$150,311**	**$0**	**$150,311**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$111,548	$57,719		$57,719	$0		$0	$0		$0	$0		$0
6	Medicaid	$53,959	$26,455		$26,455	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$225	$1,052		$1,052	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$165,732**	**$85,226**	**$0**	**$85,226**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$104,937	$55,014		$55,014	$0		$0	$0		$0	$0		$0
10	Uninsured	$9,669	$4,960		$4,960	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$8,834	$4,509		$4,509	$0		$0	$0		$0	$0		$0
13	Other	$1,153	$601		$601	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$124,593**	**$65,085**	**$0**	**$65,085**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$290,325**	**$150,311**	**$0**	**$150,311**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$9,675	$5,798		**$5,798**			**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$280,650**	**$144,513**	**$0**	**$144,513**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$9,339	$5,288		**$5,288**			**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$733	$320		**$320**			**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$290,722**	**$150,121**	**$0**	**$150,121**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$123,197	$64,454		$64,454			$0	$0		$0	$0		$0
2	Fringe Benefits	$32,298	$16,909		$16,909			$0	$0		$0	$0		$0
3	Physicians Fees	$9,915	$5,467		$5,467			$0	$0		$0	$0		$0
4	Supplies and Drugs	$47,026	$22,832		$22,832		$0	$0	$0	$0	$0	$0	$0	$0
5	Depreciation and Amortization	$11,636	$6,107		$6,107			$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]				$0			$0	$0		$0	$0		$0
7	Interest Expense	$980	$128		$128			$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$5,572	$3,343		$3,343			$0	$0		$0	$0		$0
9	Lease Expense				$0			$0	$0		$0	$0		$0
10	Other Operating Expenses	$57,937	$27,185		$27,185		$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING EXPENSES	**$288,561**	**$146,425**	**$0**	**$146,425**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$2,161**	**$3,696**	**$0**	**$3,696**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE	**$2,528**	**$503**		**$503**			**$0**	**$0**		**$0**	**$0**		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$4,689**	**$4,199**	**$0**	**$4,199**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments	**$3,000**	$1,500		**$1,500**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.7%**	**2.5%**	**0.0%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**YTD March**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
2	Hospital Non Operating Margin	**0.9%**	**0.3%**	**0.0%**	**0.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**1.6%**	**2.8%**	**0.0%**	**2.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**	**1,680**	1,691		**1,691**			**0**			**0**			**0**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	11,847	5,833		**5,833**			**0**			**0**			**0**
2	Outpatient Visits	238,522	125,267		**125,267**			**0**	0		**0**	0		**0**
	TOTAL VOLUME	**250,369**	**131,100**	**0**	**131,100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Saint Mary's Hospital (only)
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	YTD March	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$746,752	$406,827		$406,827			$0	$0		$0	$0		$0
2	Less: Allowances	$484,797	$268,852		$268,852			$0	$0		$0	$0		$0
3	Less: Charity Care	$1,854	$855		$855			$0	$0		$0	$0		$0
4	Less: Other Deductions	$4,738	$6,348		$6,348			$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$255,363**	**$130,772**	**$0**	**$130,772**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$98,115	$50,216		$50,216	$0		$0	$0		$0	$0		$0
6	Medicaid	$47,461	$23,016		$23,016	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$198	$915		$915	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$145,774**	**$74,148**	**$0**	**$74,148**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$92,300	$47,863		$47,863	$0		$0	$0		$0	$0		$0
10	Uninsured	$8,505	$4,315		$4,315	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$7,770	$3,923		$3,923	$0		$0	$0		$0	$0		$0
13	Other	$1,014	$523		$523	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$109,589**	**$56,624**	**$0**	**$56,624**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$255,363**	**$130,772**	**$0**	**$130,772**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$8,180	$4,961		**$4,961**			**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$247,183**	**$125,811**	**$0**	**$125,811**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$7,473	$4,950		**$4,950**			**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$733	$320		**$320**			**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$255,389**	**$131,081**	**$0**	**$131,081**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$88,793	$45,110		$45,110			$0	$0		$0	$0		$0
2	Fringe Benefits	$27,562	$14,267		$14,267			$0	$0		$0	$0		$0
3	Physicians Fees	$10,621	$5,693		$5,693			$0	$0		$0	$0		$0
4	Supplies and Drugs	$45,059	$21,814		$21,814		$0	$0	$0	$0	$0	$0	$0	$0
5	Depreciation and Amortization	$10,805	$5,737		$5,737			$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]	$0	$0		$0			$0	$0		$0	$0		$0
7	Interest Expense	$963	$119		$119			$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$3,802	$2,351		$2,351			$0	$0		$0	$0		$0
9	Lease Expense	$0	$0		$0			$0	$0		$0	$0		$0
10	Other Operating Expenses	$49,045	$22,512		$22,512		$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING EXPENSES	**$236,650**	**$117,603**	**$0**	**$117,603**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$18,739**	**$13,478**	**$0**	**$13,478**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE	**$2,522**	**$227**		**$227**			**$0**	**$0**		**$0**	**$0**		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$21,261**	**$13,705**	**$0**	**$13,705**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments	**$3,000**	$1,500		**$1,500**			**$0**			**$0**			**$0**

NON-PROFIT

Saint Mary's Hospital (only)

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	YTD March	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	7.3%	10.3%	0.0%	10.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	Hospital Non Operating Margin	1.0%	0.2%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	8.2%	10.4%	0.0%	10.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
D.	**FTEs**	1,384	1,387		1,387			0	0		0	0		0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges	11,847	5,833		5,833			0			0			0
2	Outpatient Visits	238,522	125,267		125,267			0	0		0	0		0
	TOTAL VOLUME	250,369	131,100	0	131,100	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Trinity Health - New England, Inc. **NON-PROFIT**

Applicant:

Financial Worksheet (A)

LINE	Total Entity:	(1) FY 2016 YTD MARCH
	Description	
A.	**OPERATING REVENUE**	
1	Total Gross Patient Revenue	$ 1,294,926
2	Less: Allowances	861,377
3	Less: Charity Care	6,479
4	Less: Other Deductions	13,560
	Net Patient Service Revenue	**$ 413,510**
5	Medicare	160,517
6	Medicaid	55,304
7	CHAMPUS & TriCare	745
8	Other	-
	Total Government	**$216,566**
9	Commercial Insurers	197,920
10	Uninsured	7,417
11	Self Pay	-
12	Workers Compensation	5,168
13	Other	-
	Total Non-Government	**$ 210,505**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$ 427,071**
14	Less: Provision for Bad Debts	11,900
	Net Patient Service Revenue less provision for bad debts	**$ 401,610**
15	Other Operating Revenue	19,795
17	Net Assets Released from Restrictions	4,035
	TOTAL OPERATING REVENUE	**$425,440**
B.	**OPERATING EXPENSES**	
1	Salaries and Wages	$ 198,862
2	Fringe Benefits	48,421
3	Physicians Fees	14,703
4	Supplies and Drugs	71,607
5	Depreciation and Amortization	23,400
6	Provision for Bad Debts-Other[b]	-
7	Interest Expense	4,745
8	Malpractice Insurance Cost	6,193
9	Lease Expense	4,826
10	Other Operating Expenses	69,195
	TOTAL OPERATING EXPENSES	**$ 441,952**
	INCOME/(LOSS) FROM OPERATIONS	**$ (16,512)**
	NON-OPERATING REVENUE	(3,332)
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$ (19,844)**
	Principal Payments	**$3,326**

Trinity Health - New England, Inc. **NON-PROFIT**

Applicant:

Financial Worksheet (A)

LINE	Total Entity:	(1) FY 2016 YTD MARCH
	Description	
C.	PROFITABILITY SUMMARY	
1	Hospital Operating Margin	-3.9%
2	Hospital Non Operating Margin	-0.8%
3	Hospital Total Margin	-4.7%
D.	FTEs	4,762.8
E.	VOLUME STATISTICS[c]	
1	Inpatient Discharges	16,345
2	Outpatient Visits	568,914
	TOTAL VOLUME	585,259

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to related to the provision of direct services to patients. For additional information, information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT C

(YTD) financial measurements
Saint Mary's Health System, Saint Mary's Hospital and
TH-NE

Saint Mary's Health System

D. Additional Statistics (in thousands)

	Year to Date March 2016	Prior Year	Explanations
Income from Operations	$ 3,696	$ 1,819	YTD net patient revenue increased $7.6 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses increased $1.9 million mostly in labor costs, offset by reductions in purchased services and medical supplies.
Revenue Over/(Under) Expense	$ 4,199	$ 4,475	The increase from operations was offset by a decrease in non operating activity associated with investment returns and joint activity.
EBITDA	$ 9,930	$ 8,095	The increase is consistent with the increase in income from operations.
Patient Cash Collected	$ 148,477	$ 136,583	The increase is associated with the increase in net revenues, along with better cash collections in current year.
Cash and Cash Equivalents	$ 19,016	$ 20,017	Cash decreased as a result of the increase in Hospital Tax payments
Net Working Capital	$ 25,933	$ 36,932	In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April 2015. This increased net working capital for March 2015 by $15 million.
Unrestricted Assets	$ 36,778	$ 37,095	The decrease in unrestricted net assets is due to the increase in Hospital Tax and increase in the underfunded status of the pension plan.
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	

	Saint Mary's Health System	Month		Year to Date	
		March 2016	Prior Year	March 2016	Prior Year
A.	**Operating Performance**				
	Operating Margin	6.9%	3.2%	2.4%	1.2%
	Non-Operating Margin	-0.6%	1.2%	0.3%	1.8%
	Total Margin	6.4%	4.4%	2.7%	3.0%
	Bad Debt as % of Gross Revenue	1.3%	1.0%	1.3%	1.2%
B.	**Liquidity**				
	Current Ratio	2.12	2.25	2.12	2.25
	Days Cash on Hand	24	26	24	26
	Days in Net Accounts Receivable	41	42	41	42
	Average Payment Period	58	57	58	57
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.24	0.63	0.24	0.63
	Long-term Debt to Capitalization	0.20	0.39	0.20	0.39
	Unrestricted Cash to Debt	1.44	0.56	1.44	0.56
	Times Interest Earned Ratio	86.4	10.5	33.87	7.11
	Debt Service Coverage Ratio	11.9	7.4	6.62	5.40
	Equity Financing Ratio	3.85	4.01	3.85	4.01
D.	**Additional Statistics**				
	Income from Operations	$ 1,967,046	$ 801,240	$ 3,695,680	$ 1,819,011
	Revenue Over/(Under) Expense	$ 1,806,716	$ 1,106,507	$ 4,198,966	$ 4,474,726
	EBITDA	$ 2,985,409	$ 1,858,696	$ 9,930,131	$ 8,095,445
	Patient Cash Collected	$ 28,863,325	$ 24,057,295	$ 148,477,112	$ 136,583,386
	Cash and Cash Equivalents	$ 19,015,875	$ 20,017,346	$ 19,015,875	$ 20,017,346
	Net Working Capital	$ 25,933,351	$ 36,931,760	$ 25,933,351	$ 36,931,760
	Unrestricted Assets	$ 36,777,596	$ 37,095,324	$ 36,777,596	$ 37,095,324
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Saint Mary's Hospital

D. Additional Statistics (in thousands)

	Year to Date March 2016	Prior Year	Explanations
Income from Operations	$ 13,478	$ 9,375	YTD net patient revenue increased $5.2 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses decreased $2.5 million mostly in purchased services and medical supplies.
Revenue Over/(Under) Expense	$ 13,705	$ 12,443	The increase from operations was partially offset by a decrease in non operating activity associated with investment return and income from joint ventures.
EBITDA	$ 19,334	$ 15,368	The increase is consistent with the increase in income from operations.
Patient Cash Collected	$ 129,772	$ 120,161	The increase is associated with the increase in net revenues, along with better cash collections in current year.
Cash and Cash Equivalents	$ 17,614	$ 19,123	Cash decreased as a result of increase in Hospital Tax payments
Net Working Capital	$ 15,067	$ 28,338	In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April. This increased net working capital for March 2015 by $15 million.
Unrestricted Assets	$ 31,729	$ 32,236	The decrease in unrestricted net assets is due to the increase in Hospital Tax, increase in the underfunded status of the pension plan and funding to the Medical Group, offset by current year performance.
Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	

	Saint Mary's Hospital	Month		Year to Date	
		March 2016	Prior Year	March 2016	Prior Year
A.	**Operating Performance**				
	Operating Margin	15.4%	7.3%	9.8%	7.1%
	Non-Operating Margin	-0.9%	2.9%	0.2%	2.3%
	Total Margin	14.5%	10.1%	10.0%	9.4%
	Bad Debt as % of Gross Revenue	1.3%	1.2%	1.2%	1.2%
B.	**Liquidity**				
	Current Ratio	1.81	2.06	1.81	2.06
	Days Cash on Hand	27	30	27	30
	Days in Net Accounts Receivable	40	41	40	41
	Average Payment Period	62	61	62	61
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.25	0.67	0.25	0.67
	Long-term Debt to Capitalization	0.20	0.40	0.20	0.40
	Unrestricted Cash to Debt	1.45	0.55	1.45	0.55
	Times Interest Earned Ratio	183.5	20.5	115.69	18.17
	Debt Service Coverage Ratio	19.3	10.5	12.89	10.25
	Equity Financing Ratio	3.87	4.04	3.87	4.04
D.	**Additional Statistics**				
	Income from Operations	$ 3,861,301	$ 1,608,253	$ 13,477,741	$ 9,374,825
	Revenue Over/(Under) Expense	$ 3,643,877	$ 2,240,864	$ 13,704,989	$ 12,442,790
	EBITDA	$ 4,830,843	$ 2,620,209	$ 19,334,355	$ 15,368,065
	Patient Cash Collected	$ 25,716,325	$ 21,143,295	$ 129,772,112	$ 120,161,386
	Cash and Cash Equivalents	$ 17,614,289	$ 19,123,132	$ 17,614,289	$ 19,123,132
	Net Working Capital	$ 15,066,620	$ 28,337,914	$ 15,066,620	$ 28,337,914
	Unrestricted Assets	$ 31,728,979	$ 32,235,922	$ 31,728,979	$ 32,235,922
	Credit Ratings (S&P, FITCH and Moody's)	Ba2	Ba2	Ba2	Ba2

Trinity Health - New England

	March 16 YTD	March 15 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	(3.9%)	1.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	2.8%	7.6%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.0	2.1	current assets/current liabilites
Days Cash on Hand	53.5	76.5	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	34.5	38.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.3	55.0	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	149.8%	117.3%	total debt/total equity(net assets)
Long-term Debt to Capitalization	60.0%	54.0%	LTD/LTD+net assets
Unrestricted Cash to Debt	46.0	62.6	(cash and cash equiv+board restr. cash)/total debt (lt & st)*100
Times Interest Earned Ratio	(2.5)	1.9	EBIT/Interest expense
Debt Service Coverage Ratio	0.9 x	2.1 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	21.8%	23.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ (16,512)	$ 5,319	Net income(loss) from operations
Revenue Over/(Under) Expense	$ (19,844)	$ (11,271)	Net gain(loss)
EBITDA	$ 11,804	$ 30,785	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 100,142	$ 127,634	from cons bs
Net Working Capital	$ 106,041	$ 123,695	current assets-current liabilities
Unrestricted Assets	$ 93,165	$ 125,633	from cons bs

CON 15-32045 Financial Statistics

Trinity Health - New England

	March 16 YTD	March 15 YTD	Explanation
D. Additional Statistics			YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry
Income(Loss) from Operations	(16,512)	5,319	fees, merger due diligence, JMMC acquisition and purchase accouting including depreciation and SFMG's increased loss of ($2.7M).
Revenue Over/(Under) Expense	(19,844)	(11,271)	Variance in swap activity of $17.8M
EBITDA	11,804	30,785	YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry fees, merger due diligence and JMMC acquisition. SFMG's YTD loss increased ($2.7M).
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	100,142	127,634	Decrease in a/p ($7.3M); increase in due from affiliates $13.7M; funds expended for tail liablility $8.5M; JMMC purchase $2.3M; decrease in supplemental payments from the State; SWAP and debt termination expenses
Net Working Capital	106,041	123,695	Decrease in cash and cash equivalents ($26.7M); decrease in a/r patient ($4.6M), decrease in a/p ($7.3M)
Unrestricted Assets	93,165	125,633	YTD loss ($16.5M); increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Prefiled Testimony of James Richard O’Connell, Executive Vice President, East Group - Trinity Health

STATE OF CONNECITUCUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
DOCKET NUMBER: 15-32045-CON
May 9, 2016

Prefilled Testimony of James Richard O'Connell, Executive Vice President, East Group

Good afternoon,

I am James Richard O'Connell, Executive Vice President, East Group, Trinity Health and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today about Trinity Health and to seek the Office of Health Care Access' approval for the continued growth of Trinity Health-New England, Inc., our Regional Health Ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the Spirit of the Gospel as a compassionate and transforming healing presence within our communities. Our five core values guide our work:

- Reverence
- Commitment to those who are poor
- Justice
- Stewardship
- Integrity

As a mission-driven innovative healthcare organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become the national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health partner for life.

We are also dedicated to building a people centered health system that allows its organization to promote efficient and effective care management initiatives. These initiatives are helping us to shift our health care delivery approach from managing episodic events to providing a system of healthcare delivery focused on preserving the wellbeing and health of each person individually within our communities.

Since we last spoke to you in July 2015, Trinity Health has grown. Today, Trinity Health is a Catholic Health Care System that operates 90 acute care hospitals in 21 states as well as a wide range of home care, hospice, senior living and programs for the elderly. Our system employs about 95,000 full time employees including 3,900 employed physicians and we are affiliated with over 23,900 private practicing physicians as well.

Trinity Health supports the addition of Saint Mary's Hospital, Inc. and its related organizations to our Regional Health Ministry as an important step in the transition from episodic care delivery to a more holistic management approach of the health of individuals. This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those who will require our services. Building a strong Regional Health Ministry requires addition of proven health providers such as Saint Mary's.

Trinity Health is excited about this opportunity. It is an honor and privilege to be here in support of this important endeavor.

I am available to answer any questions you have of me.

Prefiled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

STATE OF CONNECITUCUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
DOCKET NUMBER: 15-32045-CON
May 9, 2016

Prefilled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

Good afternoon,

I am Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc. and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital, Inc. to our growing system.

Since we formed Trinity Health-New England, Inc. in October 2015, our system and Trinity Health nationally has continued to grow.

Adding Saint Mary's Hospital, Inc. and its related entities to Trinity Health-New England, Inc. will strengthen with Saint Mary's and our system by:

- Continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality and the provision of the right care at the right time in the most appropriate health care setting;

- Improving access to capital for strategic growth and clinical service enhancements;

- Supporting future capital investments of both organizations as well as securing Saint Mary's existing and future pension liabilities;

- Supporting system-wide efforts to recruit scarce health professionals and enhance the quality of the health services delivered to our patients through participation in evidence based initiatives and medical service innovation programs.

- Preserving Saint Mary's non-profit mission and Catholic identity, with its rich history of service to the Waterbury community, spanning nearly 110 years;

As was noted in the Certificate of Need application, Saint Mary's Hospital, Inc. began its search for a partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health-New England, Inc. and two members of the Saint Mary's Hospital, Inc. community will be appointed to the Trinity Health-New England, Inc. Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health-New England, Inc. and support our continued efforts to promote the health of all those who choose to use the health services provided by Trinity Health-New England, Inc.

I am available to answer any questions you have of me.

Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System

Good afternoon,

I am Robert Mazaika and I hereby adopt my testimony as submitted to the Office of Health Care Access.

The decision to become a part of Trinity Health – New England represents the culmination of a long and arduous process for Saint Mary's.

Our search for a strategic partner has been underway for more than 10 years. During this time we have met with many hospitals and health systems from around the country. As many of you know, we have made other proposals prior to this one. However, for a number of reasons those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as the chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is truly the best possible outcome for Saint Mary's, our staff, and most importantly—the communities we serve.

Our selection process was extremely rigorous. Because we were considering our options from a position of strength, we did not need to rush in to a decision, or compromise our principles. Our task force, and our board, carefully considered a number of options over a long period of time. Throughout this period, the healthcare industry has continued to evolve at a rapid pace. However, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and in turn created a series of "Guiding Principles for Affiliation" (attached herein), which served as our litmus test for any potential partner we were considering. Those principles included philosophical, financial, strategic, and people requirements.

- The **philosophical** principles focused on maintaining our community-based Mission, improving the delivery of care, and adhering to the Ethical and Religious Directives while maintain our Catholic identity.
- The **financial** principles focused on improving the net asset value of Saint Mary's, gaining access to capital, and satisfying our pension liability.
- The **strategic** principles included improving technology and the standard of care, and gaining access to regional and national resources.
- Finally, the **people** principles were focused on improving the recruitment and retention of talent, and creating opportunities to strengthen partnerships with the medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's; they represent a direct match for our heritage, our culture, our community, and our vision of the future. The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality healthcare in a spiritually enriched environment well in to the future.

Thank you.

Guiding Principles

SMHS will utilize the following guiding principles in evaluating potential partners:

Philosophical

- Fulfill our community-based Mission
- Improve the delivery of quality care
- Adhere to Ethical and Religious Directives and secure our Catholic Identity
- Maintain local governance and provide locally-based healthcare as part of a regional or national healthcare delivery system
- Enhance our current position as a charitable health system and hospital while being open to all possible structures to best serve the interest of Saint Mary's and our community

Strategic Position

- Acquire the necessary capital to sufficiently address our strategic capital needs
- Improve technology and the overall standard of care
- Provide regional and/or national scale, leverage and resources to address Health Reform requirements
- Improve future opportunity to regionalize and rationalize the Waterbury healthcare delivery system

Financial

- Improve the net asset value of Saint Mary's
- Improve access to and cost of capital
- Fully satisfy unfunded pension liability
- Improve opportunities to reduce costs by creating efficiencies and economies of scale
- Improve revenue cycle opportunities

People

- Improve our ability to meet our obligations to our staff
- Improve recruitment and retention of talent
- Create opportunities to strengthen partnerships with the Medical Staff

Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital

Good afternoon,

I am Dr. Steven Schneider and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today.

In my role as Chief Medical Officer I am focused on working effectively with both the medical staff and leadership and management of Saint Mary's.

I am very pleased to report that the proposal to become part of Trinity Health – New England has been met with widespread support from the medical staff.

As we all know, the healthcare delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care. While most physicians recognize the need for these changes, and are, in fact helping to drive and implement them, there is a sense of uncertainty that accompanies change of this magnitude.

Here in Connecticut, and specifically Waterbury, the changing landscape has left many physicians seeking a sense of stability. Becoming part of Trinity Health – New England provides exactly the sense of confidence and clear direction that many of our medical staff members desire.

Becoming part of Trinity Health – New England will strengthen and enhance a number of critical issues, including:

Physician recruiting and retention

Maintaining a vibrant, dynamic, and stable medical staff is essential to the health of our community. This applies to both primary care physicians and specialists. Yet recruiting physicians to our community has been a challenge. Becoming part of one of the largest health systems in the nation, with all of the attendant benefits, will make us far more attractive to physicians.

Investment in technology and facilities

New physicians are being trained using the most current clinical technologies, and they expect these to be available where they practice. This applies to everything from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

Changes in the care delivery system

The care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management. Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment

Through my many discussions with the physicians in our community it is clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health – New England.

Thank you.

Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.

DOCKET NUMBER: 15-32045-CON

May 9, 2016

Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital

Good afternoon,

I am Chad Wable and I hereby adopt my testimony as submitted to the Office of Health Care Access.

This hearing represents a significant milestone in the history of Saint Mary's and I am pleased to have the opportunity to speak with you today.

I moved to Connecticut and became a member of the Saint Mary's family in 2002. One of my first responsibilities was to work with our board to develop a new strategic plan for Saint Mary's. Our first strategic imperative, as far back as 2002, was to establish a partnership. So this is something that I have been working towards literally for as long as I have been at Saint Mary's.

During the past 13 years much has changed. Saint Mary's has become a far stronger and more financially stable organization. We have made incredible progress in clinical quality and safety. We have gown and added services. All around us, the healthcare landscape has changed at an unprecedented pace. We have witnessed the passing and implementation of the Affordable Care Act, the widespread adoption of electronic health records, the introduction of value-based purchasing and population health management. Here in Connecticut the landscape has changed significantly, with hospitals moving rapidly towards a system-based delivery model.

Similarly, Saint Mary's need to join a national or regional healthcare delivery system has evolved. What was once a financially driven decision is now a purely strategic issue.

Saint Mary's vision states that we "will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives."

Becoming part of Trinity Health will help us achieve this vision and accelerate the implementation of our strategic plan. Trinity's "People 2020" strategy is perfectly aligned with ours, and joining Trinity will help us with critical issues such as scale, resources, efficiency and expertise as we make the move towards population health. The specific benefits to Saint Mary's as a result of this proposal include:

- Having access to the resources of a large system which will allow SMHS to continue to provide quality health care services in the greater Waterbury area and be able to expand those services within its service area by making them more accessible to a greater number of people;
- Having the resources necessary to help develop more preventive and primary care services in the greater Waterbury area;
- Meeting the demands of the 2010 Patient Protection and Affordable Care Act which requires an emphasis on value rather than volume in terms of reimbursement for health care services;
- Creating efficiencies so that health resources are not wasted, which will also enable more patients to be served;
- Having readily available access to capital and financing for that capital at favorable interest rates; and
- Developing a plan to address Saint Mary's pension plan obligation.

Although the details of our proposal are contained in our application, there are a few highlights that bear mentioning. This proposal is an organizational change that will allow Saint Mary's to become part of Trinity Health – New England. There is no change in clinical services requested, nor is there any change of location involved with any of the clinical services now being offered by SMHS as a direct result of this proposal. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

Additionally, Trinity Health has agreed to ensure the expenditure of One Hundred Million Dollars for capital expenditures at Saint Mary's over the first five years following the effective date of the Transaction. This committed capital will be available to support the capital needs of Saint Mary's,

including strategic growth and infrastructure development for it's integrated delivery system including both facilities and physician network development.

As a result of this Transfer Agreement, the Parties intend to:

- improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area, including SMHS's Waterbury service area;
- enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to safety and satisfaction;
- reduce the costs of healthcare in the NE-RHM Service Area, including SMHS's Waterbury service area;
- Support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

Finally, Trinity's heritage, culture, and values are a perfect match for Saint Mary's, and help make this a time of great excitement and optimism. The opportunity before us to become a member of a not-for-profit, Catholic health care organization is an extremely straight-forward transaction; however it is very significant. This transaction will cement our over100 year history into the business and healthcare fabric of Waterbury for another 100 years. The heritage and work of our founders and the Sisters of St. Joseph's will be protected. We are privileged to have the opportunity to join Trinity Health, an impressive, national, people centered organization with great talent, resources and values.

Our CON application provides much more information on this proposal.

I look forward to answering any questions you may have.

Thank you.

Closing Remarks of James Richard O’Connell, Executive Vice President, East Group - Trinity Health

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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May 9, 2016

Closing Remarks of James Richard O'Connell, Executive Vice President, East Group

Trinity Health's vision of becoming a national leader in improving the health of our communities and the most trusted health care partner for Life for each person we serve will be strengthened by the addition of Saint Mary's Hospital and Health System to our Regional Health Ministry, Trinity Health – New England, Inc.

We recognize the many challenges faced by Connecticut today, but know that forging local partnerships with committed, high quality, non- profit health care providers is the key to ensuring a truly integrated health system that promote better healthcare for all.

We also believe that preserving Catholic healthcare institutions is also critically important to ensuring our unique approach will provide the neediest people in each local community the access to care they deserve.

Thank you for your continued support of Trinity Health's collective efforts to create a better tomorrow for all we serve.

Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

Since 2015 when Trinity Health - New England Inc. was formed our goal of offering people centered health care closer to home has made significant strides in a very short time. Our efforts toward improving population health, enhancing the patient care experience and controlling cost while maintaining a positive margin will be strengthened with the addition of Saint Mary's Hospital and Health System to our organization.

Equally important the 100 plus years of Saint Mary's exemplary service to the Waterbury community is both preserved and strengthened.

If approved, together the organizations that would constitute Trinity Health – New England, Inc. represent over 300 years of continuous, high quality, non –profit health care service delivery to multiple communities across the state of Connecticut.

Our institutions are open 24 hours a day, seven days a week to all in need. Trinity Health – New England Inc. is truly a part of the fabric of Connecticut's health system. Please support its efforts to continue to serve the citizens of Connecticut for another hundred years.

Thank you very much.

Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital

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CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.
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Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital

Saint Mary's is integral to the fabric of Greater Waterbury. This proposal will position us to maintain our identity as a faith-based, not-for-profit hospital and continue our great tradition of service to the community for many years to come.

Becoming part of a regional or national system has been at the core of our strategic plan for many years. Trinity Health provides all of the resources and expertise needed to accelerate and implement our strategic plan, while also honoring our faith based heritage and deep community roots. Our collective commitment to people-centered care will be the foundation of all that we do.

The creation and growth of a strong, progressive regional health ministry serving New England positions Saint Mary's to effectively deal with the shift to population health management and other changes in the healthcare delivery system locally and regionally. Our ability to invest in our future will help us to attract and retain the most talented physician and caregivers, and provide our patients and families with the most appropriate standard of care.

Our vision of the future is bright. On behalf of the 2,000 members of the Saint Mary's family we look forward to having our proposal approved so we can begin the exciting work of making our vision a reality.

Thank you for the opportunity to present our proposal.

Greer, Leslie

From: Mercier, Carlene M. <CMercier@brownrudnick.com>
Sent: Tuesday, May 10, 2016 1:45 PM
To: User, OHCA
Cc: chartley@stfranciscare.org; Anthony, Robert J.; Teitelbaum, Claudia S.; helmecki@ct.gov
Subject: Docket No. 15-32045-CON / Appearance
Attachments: Saint Mary_s _ Trinity - Appearance for R. Anthony.PDF

Hello,

Attached for filing in Docket No. 15-32045 (Saint Mary's / Trinity - Transfer of Ownership) is an Appearance for Bob Anthony on behalf of Saint Mary's. Please let me know if you need anything further.

Best Regards,
Carlene

BROWNRUDNICK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE	:	**Docket No. 15-32045-CON**
	:	
CERTIFICATE OF NEED APPLICATION FOR SAINT MARY'S HEALTH SYSTEM, INC. AND SAINT MARY'S HOSPITAL, INC.'S TRANSFER OF OWNERSHIP AND CONTROL TO TRINITY HEALTH – NEW ENGLAND, INC., FORMERLY KNOWN AS SAINT FRANCIS CARE, INC.	:	**MAY 10, 2016**

APPEARANCE

An appearance on behalf of Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. in the above-mentioned docket is hereby submitted.

Robert J. Anthony, Esq.
Brown Rudnick LLP
CityPlace 1
185 Asylum Street
Hartford, CT 06103
Tel. 860-509-6517
Email: ranthony@brownrudnick.com

Respectfully Submitted,

Robert J. Anthony/cm

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

SAINT MARY'S HEALTH SYSTEM, INC.
TRINITY HEALTH, INC.

TRANSFER OF OWNERSHIP OF SAINT MARY'S HOSPITAL SYSTEM TO TRINITY HEALTH, INC.

DOCKET NO. 15-32045-CON

MAY 9, 2016

3:00 P.M.

COURTYARD BY MARRIOTT WATERBURY
63 GRAND STREET
WATERBURY, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Saint Mary's Health System, Inc., Trinity Health, Inc., transfer of ownership of Saint Mary's Hospital System to Trinity Health, Inc., held at the Courtyard by Marriott Waterbury, 63 Grand Street, Waterbury, Connecticut, on May 9, 2016 at 3:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Okay, folks, we're going to get started here. Okay, we're on the record. Good afternoon, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 15-32045-CON, is being held on May 9, 2016 to consider Saint Mary's Health System, Inc. and Trinity Health, Inc.'s application for the transfer of ownership of Saint Mary's Hospital system to Trinity Health, Inc.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General

Statutes.

My name is Kevin Hansted, and I have been designated to serve as the Hearing Officer for this matter.

The staff members assigned to this case are Kaila Riggott, Jessica Schaeffer-Helmecki, David Fernandes and Ronald Ciesones. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Saint Mary's Health System, Inc. and Trinity Health Corporation have been designated as parties in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this matter.

All documents have been identified in the Table of the Record for reference purposes.

MS. JESSICA SCHAEFFER-HELMECKI: My name is Jessica Schaeffer-Helmecki, and, on behalf of OHCA, I'd like to request that Exhibits A through L be entered into the record.

HEARING OFFICER HANSTED: Thank you. And there is one correction I'd like to make, just one bit of housekeeping.

On the order regarding administrative notice, dated April 27, 2016, which is Exhibit K on the Table of the Record, in that order, letter B, it says Exhibit D, completeness responses, page 1974. The page number should be 1947.

Does the Applicant have any objection to any of the exhibits? No objection? If you could just state that on the record?

MR. CHRIS HARTLEY: Chris Hartley, St. Francis. For the record, no.

HEARING OFFICER HANSTED: Okay, thank you. And for this afternoon's hearing, we will first hear from the Applicant for an overview of the project, and then, if there are any individuals signed up to give public comment, we will hear from them.

We, of course, will take elected officials first, and then read the names off of the public comment sign-up sheet in the order that they have signed up.

Then, after the public comment, we will have some questions from OHCA, and then, if there are any other public commenters, we will take them at that time.

And, at this point, would all the individuals, who are going to or think they may testify, please stand, raise your right hand and be sworn in by the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay, thank you, all. And just for clarity on the record, each of you, who have just taken the oath, would you please identify yourself in one of the microphones closest to you, including the folks sitting in the back rows? Whoever wants to start can do so.

MR. RALPH BECKER: Ralph Becker with Saint Mary's.

MR. DAVID BITTNER: David Bittner. I'm the Chief Financial Officer for Trinity Health New England.

MS. JENNIFER SCHNEIDER: Jennifer Schneider, Vice President of Finance, St. Francis Hospital and Medical Center.

MR. HARTLEY: Chris Hartley, St. Francis.

MR. CHRISTOPHER DADLEZ: Christopher Dadlez, President and CEO, Trinity Health New England.

MR. JAMES RICHARD O'CONNELL: James

Richard O'Connell, Trinity Health.

MR. CHAD WABLE: Chad Wable, President and CEO, Saint Mary's Hospital and Saint Mary's Health System.

MR. ROBERT MAZAIKA: Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System.

DR. STEVEN SCHNEIDER: Dr. Steve Schneider, Chief Medical Officer, Saint Mary's Hospital.

MR. JOE CONNOLLY: Joe Connolly, Vice President of Administration, Saint Mary's Hospital.

MR. BOB ANTHONY: Bob Anthony, attorney for Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay, thank you. And I know we have some folks in the second row.

DR. ADAM SILVERMAN: Adam Silverman, Vice President, Ambulatory Strategy, Trinity Health New England.

DR. MARCUS McKINNEY: Marcus McKinney, Vice President of Community Health, Trinity Health New England.

MR. MICHAEL TALBERT: Michael Talbert, attorney for Trinity Health New England.

MS. LIZ RODAREO: Liz Rodareo, St. Francis Hospital.

MR. JIM HARRIS: Jim Harris, Trinity Health New England.

MR. JURCZYK: Kyle Jurczyk, Saint Mary's Hospital.

MR. CHRIS HAYES: Chris Hayes, Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay. I think that's everyone. And for the two attorneys that are present here today, I know we have one for the hospital and one for Trinity, do you intend on filing appearances in this matter?

MR. ANTHONY: Yes. This is Bob Anthony. Yes, we do.

HEARING OFFICER HANSTED: Okay. All right. Would you just file those this week, just so I have them on the record? Thank you.

Okay, at this point, the Applicants may proceed with their opening presentation.

MR. O'CONNELL: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. O'CONNELL: I'm James Richard O'Connell, Executive Vice President of the East Group for Trinity Health, and I hereby adopt my testimony, as submitted for the Office of Health Care Access.

HEARING OFFICER HANSTED: Thank you.

MR. O'CONNELL: Thank you for the opportunity to speak to you today about Trinity Health and to seek the Office of Health Care Access approval for the continued growth of Trinity Health New England, Inc., our regional health ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the spirit of the gospel as a compassionate and transforming, healing presence within our communities.

Our five core values guide our work; reverence, commitment to those who are poor, justice, stewardship, integrity.

As a mission-driven innovative health care organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become a national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health care partner for

life.

We are also dedicated to building a people-centered health care system that allows its organization to promote efficient and effective care management initiatives.

These initiatives are helping us to shift our health care delivery approach for managing episodic events to providing a system of health care delivery focused on preserving the well-being and health of each person individually within our communities.

Since we last spoke to you in July of 2015, Trinity Health has grown. Today, Trinity Health is a Catholic health care system that operates 90 acute care hospitals in 21 states, as well as a wide range of home care, hospice, senior living and programs for the elderly.

Our system employs about 95,000 full-time employees, including 3,900 employed physicians, and we are affiliated with over 23,900 private practicing physicians, as well.

Trinity Health supports the addition of St. Mary's Hospital, Inc. and its related organizations to our regional health ministry as an important step in the transition from episodic care delivery to the more

holistic management approach of the health care of individuals.

This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those, who require our services.

Building a strong regional health ministry requires addition of proven health providers, such as Saint Mary's. Trinity Health is excited about this opportunity. It is an honor and a privilege to be here in support of this important endeavor.

I'm available to answer any questions you may have of me.

HEARING OFFICER HANSTED: Thank you.

MR. DADLEZ: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. DADLEZ: I'm Christopher M. Dadlez, President and CEO of Trinity Health New England, and I hereby adopt my testimony, as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital to our growing system.

Since we formed Trinity Health New England

in October of 2015, our system and Trinity Health nationally has continued to grow. Adding Saint Mary's Hospital and its related entities to Trinity Health New England will strengthen Saint Mary's and our system by continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality, and the provision of the right care at the right time in the most appropriate health care setting.

Improving access to capital for strategic growth and clinical service enhancements, supporting future capital investments at both organizations, as well as securing Saint Mary's existing and future pension liabilities, supporting system-wide efforts to recruit scarce health care professionals and enhance the quality of the health services delivered to our patients through participation in evidence-based initiatives and medical service innovation programs.

Also, preserving Saint Mary's not-for-profit mission and Catholic identity with its rich history of service to the Waterbury community spanning nearly 110 years.

As was noted in the Certificate of Need application, Saint Mary's Hospital began its search for a

partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health New England, and two members of the Saint Mary's Hospital community will be appointed to the Trinity Health New England Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health New England and support our continued efforts to promote the health of all those, who choose to use the health services provided by Trinity Health New England, Inc.

I'm available to answer any questions you may have. Thank you so much.

HEARING OFFICER HANSTED: Thank you.

MR. WABLE: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. WABLE: I'm Chad Wable, President and CEO of Saint Mary's Hospital and Saint Mary's Health System, and I hereby adopt my pre-filed testimony.

First of all, I'd like to thank all of you for bringing us together today for this very important hearing. I want to thank all of you and the involved agencies for the diligence and work in reviewing our application.

Since 2002, Saint Mary's saw the value and

importance in forming a broader, larger partnership with a national or regional system. Over the past decade, we've been truly blessed to have been able to grow stronger and more stable and to affirm ourselves as a highly-respected and trusted hospital and health care company.

We have added services and programs. We have added numerous jobs. We have added several physicians and clinicians to our medical group and medical staff to better serve the Greater Waterbury area.

Everything we do at Saint Mary's is grounded in our Catholic values and mission and focused by our vision, a vision perfectly aligned with Trinity's vision and their People 2020 strategy.

Joining Trinity is almost surreal to me, considering what we have been able to accomplish independently and our many attempts at forming a larger, broader strategic partnership through the years.

This partnership with Trinity Health is so perfect for us and so perfect for our people in our community. The scale, the resources, the efficiency and expertise will certainly move us towards our collective vision of value in population health.

The benefits to Saint Mary's of joining

Trinity Health are endless. Our proposal was so straightforward, Catholic-to-Catholic, not-for-profit and not-for-profit and so on.

And through our member substitution, there's nearly no organizational changes, no service changes, and no exchange of money.

What does change is we, in our community, get a great deal of stability, security, certainty and confidence in Saint Mary's, confidence in health care for Waterbury, and confidence for the health of our community as we look so positively to the future.

This is a time of great enthusiasm, a time of great excitement, and a time of great optimism for the entire Saint Mary's family and for the Greater Waterbury community.

What is most perfect is this transaction will cement our over 100-year history into the business and health care fabric of Waterbury for another 100 years.

The heritage and work of our founders and sisters of St. Joseph's will be protected, and it will live on with great hope and promise.

We are privileged to have the opportunity to join Trinity Health, an impressive, national, people-

centered organization, with great talent, resources and values.

I look forward to answering any questions that you may have.

HEARING OFFICER HANSTED: Thank you.

MR. MAZAIKA: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. MAZAIKA: I'm Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System. I hereby adopt my testimony, as submitted to the Office of Health Care Access.

The decision to become part of Trinity Health New England represents the culmination of a long and arduous process for Saint Mary's Health System.

Our search for a strategic partner has been underway for more than 10 years. During this time, we have met with many hospitals and health systems from around the country.

As many of you know, we have made other proposals prior to this one, however, for a number of reasons, those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as Chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is

truly the best possible outcome for Saint Mary's, our staff, and, most importantly, the communities we serve.

Our selection process was extremely rigorous, because we were considering our options from a position of strength. We did not need to rush into a decision or compromise our principles.

Our Task Force and our Board carefully considered a number of options over a long period of time. Throughout this period, the health care industry has continued to evolve at a rapid pace, however, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and, in turn, created a series of guiding principles for affiliation, which served as our litmus test for any potential partner we were considering.

Those principles included philosophical, financial, strategic and people requirements. The philosophical principles focused on maintaining our community-based mission, improving the delivery of care, and adhering to the ethical and religious directives, while maintaining our Catholic identity.

The financial principles focused on improving the net asset value of Saint Mary's, gaining

access to capital, and satisfying our pension liability. The strategic principles included improving technology and the standard of care and gaining access to regional and national resources.

Finally, the people principles were focused on improving the recruitment and retention of talent and creating opportunities to strengthen partnerships with our medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's. They represent a direct match for our heritage, our culture, our community and our vision for the future.

The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians, who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality health care in a

spiritually-enriched environment well into the future.

Thank you very much for your attention.

HEARING OFFICER HANSTED: Thank you.

DR. SCHNEIDER: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

DR. SCHNEIDER: I am Dr. Steve Schneider, Chief Medical Officer at Saint Mary's Hospital, and I hereby adopt my testimony, as submitted to the Office of Health Care Access. Thank you very much for the opportunity to speak with you today.

In my role at the hospital as Chief Medical Officer, I am focused primarily on working effectively with both the medical staff and the leadership and management of Saint Mary's Hospital.

I am very pleased to report that the proposal to become part of Trinity Health New England has been met with widespread support from our medical staff.

As we all know, the health care delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care.

While most physicians recognize the need for these changes and are, in fact, helping to drive and implement them, there is a sense of uncertainty that

accompanies change of this magnitude.

Here in Connecticut and, specifically, in Waterbury, the changing landscape has left many physicians seeking a sense of stability.

Becoming part of Trinity Health New England provides exactly that sense of confidence and clear direction that many of our medical staff members and physicians in the community desire.

Becoming part of Trinity Health New England will strengthen and enhance a number of critical issues, including first physician recruiting and retention. Maintaining a vibrant dynamic and stable medical staff is essential to the health and well-being of the community.

This applies to both primary care physicians and specialists, yet recruiting physicians to our community has been a challenge.

Becoming one of the largest health systems in the nation, with all of the benefits, will make us far more attractive to physicians.

Next, investment and technology and facilities. New physicians are being trained using the most current clinical technologies, and they expect these technologies to be available where they practice.

This applies to everything, from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

Lastly, changes in the health care delivery system, itself. The health care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management.

Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment.

Through my many discussions with physicians in our community, it's clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action that this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health New England. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. HARTLEY: That concludes our initial presentation.

HEARING OFFICER HANSTED: Okay, thank you.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: We will go to OHCA's questions. Ms. Riggott, do you want to begin?

MS. KAILA RIGGOTT: Sure. Kaila Riggott, OHCA staff. I'm not sure. There may be different individuals, who will answer these questions, so I'll just pose them generally.

Based on your application, pre-filed testimony, etcetera, OHCA has certain areas of interest we'd like to have a brief discussion about and also want to understand if you have any concerns or challenges regarding them. These would include CHNAs, community benefit, Board makeup, etcetera.

You've mentioned in your response to OHCA's interrogatories that the CHNA is scheduled to be completed in June and the implementation plan mid-November.

In your application, you stated that the New England Regional Health Ministry and Saint Mary's are currently addressing the community needs within the Saint

Mary's community and will continue to do so if the CON is approved.

Specifically, how will this proposal affect the implementation plan being developed to address priority health needs identified in the CHNA, how does Trinity and the Regional Health Ministry support the CHNA, and how will they be participating in the process?

MR. HARTLEY: Chris Hartley of St. Francis. I want to ask Joe Connolly to speak to where things stand on the Waterbury Community Health Needs Assessment, and then Dr. Marcus McKinney will talk about how we're integrating that with what we're doing in the rest of Trinity Health New England that ties to the Community Health Needs Assessment and Strategic Implementation Plan you raised as a question. Joe, you want to start?

MR. CONNOLLY: Sure. I'm Joe Connolly from Saint Mary's, and, as Bill Quinn said, we have a very robust partnership here in Waterbury that Saint Mary's is a founding partner of, both participation not only from health care providers, but, in addition to that, some of the other funders in the city, both of our large philanthropies are involved, and it's been an ongoing process.

We've used research that was conducted in 2013 when we did our initial needs assessment. We've re-upped and had another round of research that was completed earlier this year.

As opposed to changing anything, I think it's a refocusing, so, for instance, where we were talking about some of our chronic health conditions last time, this year, for instance, we're going to be looking at a more narrow focus on asthma, which is consistent with what's going on at the Connecticut Hospital Association, consistent with other programs here in the state, so I think that it's an evolution and a refocusing and a continuing of what has been set forth, and there's ongoing communication from all the partners to make sure that that work continues.

And, as Chris just alluded to, Marcus McKinney could add to that, but we certainly see, from the Saint Mary's perspective, that the experience and commitment that St. Francis is bringing to that and Trinity Health is going to help accelerate that and provide some perspective that we might not already have here in our community.

DR. McKINNEY: Hi. Marcus McKinney, Vice President for Community Health for Trinity Health New

England.

So several things surface to the top to try to address how we support for Trinity Health New England, the Waterbury area and Saint Mary's.

First, we would refer to the hub of community health and health equity work at our Trinity Health New England system is the Curtis D. Robinson Center for Health Equity.

That will be an approach that will allow for team extension into Waterbury, as it has in Springfield and in Hartford and for Johnson Hospital, Johnson Memorial Hospital.

That is a team of eight individuals, multi-cultural, multi-lingual, that really amends Vice President Connolly's comments, and, also, I would refer back to the earlier comments of the Director of Health in Waterbury, because the community health strategy that Trinity referenced to be a speaker of at ACHI meeting, the Community Health Improvement meeting in March, really is community health and well-being.

So what we would be glad to do for you is really highlight that the community health and well-being is the strategy, and well-being touches all those social determinant issues, so the strategy baits into the

priories of obesity, tobacco, to be at the highest level of concern for strategies that's already in the Greater Waterbury strategy, the partnership that was mentioned by the Director of Health, but really would be able to amend it by the resources and insight from a regional approach, which includes Hartford.

So our Center for Health Equity and the fact that we're looking at well-being and where are we getting that from, we're getting the information from the existing health needs assessment that's taking place by DataHaven, and DataHaven you may remember, some of you, is a first of its kind health and well-being assessment in this country, and it's for all of our hospitals that are implicated here in Connecticut.

So we have the first set of questions from the community that touches on social determinate issues. That will help inform implementation plans to support the Waterbury region and Saint Mary's.

MR. DADLEZ: In addition, we also had the national initiatives at the corporate headquarters of Trinity and Detroit, where we have a Senior Vice President for Community Outreach and his whole team that is providing resources for the regional ministries, in addition, so this is a comprehensive commitment that

Trinity Health has made significantly to the communities that it serves.

One of its primary focus is community outreach and community health and well-being and the people that we serve, so there are dramatic resources throughout the whole organization that are available.

MS. RIGGOTT: And just to follow-up on that, the resources would consist of?

MR. DADLEZ: First of all, resources that consist of the talent and the content experts that we have, both on a national level and a regional level.

I mean I think that first the priority is the mindfulness of that and the focus that we have and those people that have been trained and have been doing this work for years and years.

There's also a financial commitment that Trinity basically has set aside a significant portion of its budget this past year to really focus on things, like obesity and tobacco use and those kind of things in all the different regions comprehensively across the state.

They setup specific guides and parameters and expectations for each of the health ministries to meet all across the nation, so this is kind of -- the point is it's hardwired into what we do, and it's a very

significant commitment.

MS. RIGGOTT: Thank you. In the application, it was stated that, for Trinity Health, success will be measured against the triple aim objectives, its ability to actually deliver on all three dimensions of better health, better care and reduced costs.

Does Trinity have any outcome data on which to measure these successes?

MR. O'CONNELL: This is James O'Connell from Trinity Health.

We have a lot of outcome measures and a lot of strategic aims. What we've done is positioned ourselves to where we want to be in the top quartile by 2020 in all of our ministries across the organization, and those are all measured differently, so lowest cost provider, highest quality and highest satisfaction.

We use national data to benchmark against, so it's the HCAHPS for the patient care experience. Quality, we have a very sophisticated quality score card that measures across the full continuum of services that we have, and we compute that into GPA, and we have all of our facilities measured on that every month along the way, so we know, prior to something happening, that we're

going in the wrong direction, or we're going in the right direction, so we use those measures for our success.

The truth will be, you know, for those payers at the end of the day, who want to contract with us to provide their care, because they're going to look for the highest quality, lowest cost facilities available, and we hope to have 75 percent of all of our contractual arrangements in an alternative payment form by 2020. That's our other measure.

MS. RIGGOTT: Thank you. Next question. OHCA is interested in encouraging community building activities that are aimed at addressing the social and economic determinants of health and examining the outcomes and cost effectiveness of improvements that result from community building activities.

Saint Mary's most recently submitted 990s. I believe it shows that physical improvements and workforce development appeared under the community building activities.

With respect to community benefit and community building, are there plans to align with the CDC's 618 initiatives interventions and/or Healthy People 2020?

MR. CONNOLLY: The CDC program is one that

we participated in as a community this year, and the asset not only is Saint Mary's, but throughout the rest of the community, as well, so I think that it was -- we spent six months studying that. We had representatives actually participate in the meeting where a lot of those initiatives were laid out, and the recommendations that we are making not only to ourselves as an organization, but community-wide, are completely consistent with that, so I would say yes.

MS. RIGGOTT: Okay. In your application, also, you state that Saint Mary's is committed to supporting its community and is projecting a three percent increase annually as part of New England Regional Health Ministry, and Saint Mary's will be able to collaborate on planning activities on a regional level, leveraging the expertise and resources of the Regional Health Ministry.

Can you please confirm your plans to increase the level of community benefit provided as a result of this acquisition?

MR. HARTLEY: Can you tell us what page you're referring to?

MS. RIGGOTT: I believe it's page 85. I believe it mentions projecting a three percent increase

per year. I may not have the right page. It's at the response to the first part of --

MR. HARTLEY: Chris Hartley. I believe you're talking about the response above on Exhibit S6? Is that what you're talking about?

MS. RIGGOTT: Um-hum. Yeah. It refers to Exhibit 17, question O.

MR. HARTLEY: Chris Hartley, St. Francis. We're looking at page A46. This is talking about the increase in community benefits that's measured each year through our community benefits report and looks at how much increase in delivery of community benefits we've had.

If you look at our latest community benefit report for St. Francis, the actual $78 million we gave in 2014 in community benefits is measured by that program. It actually went to 104 million in 2015, primarily driven by the shortfalls in Medicaid payments for care and other government payments.

So one of the biggest contributors for the growth in that area is the continued reduction in provision of payments for Medicaid and Medicare patients that use services, and that commitment to continue to grow is basically exceeding three percent at this point

in time, and we'll continue that commitment to the patients that need our care, and, unfortunately, that care payment has been continually reduced as part of the program. That's what that's referred to.

MS. RIGGOTT: Thank you. And then, with respect to charity care, can you confirm for the record that you are committed to either maintaining or increasing the level of charity care as a result of the acquisition, and there would be no concerns in notifying OHCA if there were any changes in that level?

MR. HARTLEY: We provided information in the application that says that our charity care policies will continue. There should be no change.

What we did in the earlier applications, we actually met the most stringent standards of Trinity Health Care for our previous parts of the system. We'll continue to do it with Saint Mary's as part of the program.

MS. RIGGOTT: Thank you. My next question is regarding evidence-based initiatives. Mr. Dadlez, you mentioned in your pre-filed testimony the acquisition will enhance the quality of health services delivered to patients through participation in evidence-based initiatives and medical service innovation.

Can you elaborate a bit and discuss your top proprieties with respect to these initiatives and innovation?

MR. DADLEZ: Let me think what the best answer to that is. Pulling together an organization, such as we are, offers a tremendous opportunity to really develop and foster and grow really top quality health programs.

Because we have the size and the intellectual capital of our clinical enterprise that is in a regional basis and together with the intellectual capital and all the research and development and resources of Trinity Health, that's a national organization that's looking at all these quality initiatives, we're going to be working together in bringing people together on many, many clinical initiatives.

It's not just -- it's hard to say, you know, just one. There are many clinical initiatives, where we will get synergies, and we will be able to become more efficient and effective and raise the bar on creating standards of care.

So what we're going to be doing is are standardizing and taking variation out of the system and

creating a greater opportunity to really provide the utmost care, so, for example, we have three bariatric programs currently in our region.

They're all independent. They all have their own individual standards of care, and what we're doing are pulling together leadership in those, as an example, in that clinical entity, and all of those individuals will be looking at and fostering and developing what's the best clinical programming as a system and raising the bar and saying this is a better way of taking care of those bariatric patients.

For example, we may not need three centers. Maybe it will be better to consolidate some of those operations and just do them in Waterbury or whatever we believe, but the opportunity is to bring all those people together and really use their expertise and clinically develop those types of initiatives.

We can have other people to even address that. I don't know if you would want to, or maybe Dr. Silverman, or others may want to comment on that.

MR. HARTLEY: Chris Hartley. If you refer to page 1027 and 1028 of the application ?? there we list some of the ways in which working with Trinity will bring additional quality initiatives ??

One of the things Trinity has is the universal -- there's a clinical access system that we use as part of our organization that basically sets standards for physicians' care across all of our system, uses evidence-based practices to deliver that care.

We see that employed also through our clinical service centers of excellence that will manage to map those centers of excellence with those at Saint Mary's using standard protocols across all of our system to ensure common clinical protocols and common treatment as part of the program.

We also basically are going to be using similar clinical protocols for all our physician groups throughout the system, which ensures common treatment for patients, as well as the same health information system across all of our system, again, being able to move patients within our system and keep the same medical records and keep the information together for those patients. It's part of our initiative to raise the quality of care there.

Actually, this is a question that should be answered by a clinician. I'm not a clinician, so, Adam, Dr. Silverman, you may want to comment on this.

DR. SILVERMAN: Hi. Adam Silverman, Vice

President for Ambulatory Strategy at Trinity Health New England.

I think Mr. Hartley started to get into where I believe the real value of bringing Trinity Health to Connecticut and Western Massachusetts is really benefitting the patients through the clinicians on the ground, and part of that is this unified clinical organization that Mr. Hartley was describing, where, regardless of what program we're talking about, what we want to look for across our system and the real value of the system is to find what I'll call best in breed, so who is doing best in whatever program we're talking about.

It could be an open heart program. It could be an obesity program. It could be care of the elderly. How do we keep the older adult population living independently longer?

Up until now, it's been what locally we have in our own particular organizations that really have driven sort of either the evidence-based or, when the evidence is lacking, the best practice.

Now we have partners across the country in 22 states, who have struggled with the same thing. Some are a bit ahead of us, some are a bit behind us, and it

saves us from having to recreate the wheel, so we can bring that evidence-based or that best practice to bear more rapidly by being connected to this unified clinical organization for our physicians.

Rather than go program-by-program, it's who are the high-risk patients? Who are the ones that we need to identify today, who are going to be our patients tomorrow? How do we keep them healthier? How do we keep them out of the hospital? How do we keep them out of the emergency room? How do we reduce the cost and the time that they spend in the health care system, and how do we improve their overall well-being moving forward?

MS. RIGGOTT: Thank you.

MR. HARTLEY: Chris Hartley. Just one other thing to point out. This is multi-dimensional. Basically, we work with Trinity Health on the state and local basis on legislative changes that are necessary to encourage program development.

On Tobacco 21, for example, what we think is a best care scenario. Basically, we help to work passing an increase in the smoking age from 18 to 21. We didn't succeed this year, but that's part of Trinity's ongoing initiatives across the country, to move the tobacco age up, because there's evidence base that if you

move the age up for people to begin smoking, fewer people actually start.

We also work with obesity programs nationally, and we look at them locally to try to promote those programs, as well, as part of our evidence-based practice at reducing obesity, particularly in the poor populations, as a way to manage a variety of health issues, including diabetes, amongst others, so we're part of that.

We're part of a national what's called a Tiger Teams Initiative to expand access to behavioral health services nationally, on a national level and locally, to make sure that we have mental health parity for all patients and families in this community, so those are all initiatives that we work on, as well, as we work with Trinity to try to move those issues forward nationally and statewide.

MS. RIGGOTT: Thank you. My next question is for Mr. Wable. You mentioned in your pre-filed testimony via the transfer agreement that parties intend to reduce the cost of health care in the New England Regional Health Ministry service area and St. Mary's Waterbury service area.

Can you elaborate on how this is intended

to be accomplished?

MR. WABLE: Sure. I think there's probably multiple ways that this will be attended to. I think, first, on the local level, we're always looking at ways to be more efficient, through better productivity management, better management across the entire health system. That's the first and foremost, is what can we do locally?

Regionally, we're going to be able to then work together to figure out where there might be a certain amount of synergies where we can work better together.

An example of that is through supply chain alone, both on the regional and national level. Hopefully, we'll be able to buy products and services at a lower cost as a result of multiple parties working together to accomplish that. That's another example.

The third way will be best practices across all the different entities, so each one of us may take care of a surgical patient or a medical patient a little different than one another, being able to have forums, where physicians and clinicians and administrators can come together and learn what those best practices might be and roll those out within a

region or use national best practices to roll out where there have been either cost saving, evidence of cost savings nationally, or regionally, or otherwise, where we can continue to reduce cost, and I think, through all of those prongs, we will be able to reduce costs over time.

MS. RIGGOTT: Okay, thank you. My next question is regarding the makeup of the Board. In the application, it was stated that the New England Regional Health Ministry Board of Directors will appoint two members from the Saint Mary's community to the Board.

It's important to OHCA to have true community representation on the Board, and I'm wondering if there are alternatives to having community members selected by the Board.

We are most interested in someone, who can bring the community's concerns to the hospital and likewise bring hospital information to the community.

MR. DADLEZ: Well I'm sure you know that the organization is a community not-for-profit organization, and all the Board members that serve are volunteer Board members that are community representatives, so we think we do a great job in identifying individuals that represent the community.

We're really focusing on making sure that

they're reflective of the community and trying to get more minority representation and others on our Board, but we feel that those individuals that are currently in place and the potential folks that are coming on board do reflect and bring that community representation, so I'm not sure what other suggestions you might have, but we think that they're incredible advocates for their communities and have done a really outstanding job over the years representing the community, so we feel we're in good shape, but I don't know whether, you know, what, specifically.

MR. HARTLEY: I think it's evidenced by the public testimony and the letters that are in our application. There is no apparent concern about the level of representation we have provided to the community in the past. We're remaining not-for-profit.

We continue to provide plenty of access to our community health and needs assessment and other activities to services and needs in the community and will continue to do so.

MR. DADLEZ: We also have many other avenues of community representation. For example, our Curtis Robinson Center for Health Equity has a very comprehensive Advisory Board that brings together leaders

in the community that are really focused on health equity and their issues. All that information bubbles up to the regional Board. All our local Boards have community representation, that, in addition, they focus on the quality, on the immediate local needs of those communities.

All that information comes up to the Board, so one of the things of a well-functioning Board is not to have an overwhelming volume of people on it, because you'll never get anything done.

You want to have the correct number of folks on there and make sure that you're really implementing the strategic direction for the community, so you don't want to overwhelm it, you don't want to overburden it, but you want to make sure all the correct information comes up to the regional Board, and I think that we're doing a very good job at it right now in my estimation.

MS. RIGGOTT: Thank you. With respect to a three-year service plan, are there concerns regarding submitting to OHCA a plan describing any consolidation reduction, elimination, or expansion of existing services, or introduction of new services?

MR. HARTLEY: Chris Hartley, St. Francis.

I think the issue here is threefold. One, it is a health service. What is a health service, and what are we talking about, and, also, recognizing the dynamic nature of health care right now, projecting today, and we will be happy to commit to what we're providing services now.

Without taking into account the changes that are rapidly occurring in the health care system, the changes in reimbursement, and, actually, the changes in the way we deliver health care potentially could lock in place services without service change that are not appropriate to do at this point in time, but, clearly, our intention is to continue to provide health services in this community over the three-year time frame that's talked about, but there's nothing magic about three years.

The issue here is to make sure that we do care in the right place, the right way, at the right time, and that's going to change over time, and it's going to be focused more and more on prevention and maintaining the total health of a person over time, so, yes, the concern would be artificially locking in place an ill thought out definition of health services that doesn't give us the flexibility to change with the way health care, itself, is changing in a rapid fashion.

As you know, some of the things that we've talked about today, even the input of the Community Health Needs Assessment, isn't available at this point in time. When this is finished and available, there may be some new areas that identify for us as part of that.

Clearly, the reimbursement changes that are going on have impacts and pressures on all health care providers, and working with others in the collaboration may change the way we deliver that health care in the future, and we've got to look at that and think of that as we go forward together, but, clearly, our intention remains to provide the health services that we have today tomorrow, but perhaps in a different way, and we can't predict all those ways at this point in time.

MS. RIGGOTT: Thank you. Any my last question involves the capital investment plan. Are there any concerns with submitting to OHCA within a specified time frame a capital investment plan, detailing a list of planned capital expenditures with descriptions and associated estimated costs and time frames?

MR. BITTNER: I think, with -- David Bittner. I think that any capital planning I think both our organizations, St. Mary's and Trinity Health, Trinity

Health New England, try to plan out capital in a three-year, five-year kind of time frame, however, even in a single year, it's hard to predict that the capital that we planned this year for next fiscal year that we'll spend all that capital exactly how we've outlined, those capital spends.

I think we've provided to OHCA in a series of reports those kind of capital expenditures that we kind of foresee, in terms of facilities, equipment, technology, as well as other kind of future opportunities that we haven't identified what those opportunities are.

We have provided, I think, at least in the last, next couple of years related to capital, but, from the specificity around which pieces of equipment or which facilities are those that I don't think we have -- able to commit to, simply because even when we have a fiscal year budget over a 12-month period, those change on a month-to-month basis, depending on availability of capital, what's happening with funding from the state and the federal side, as well, which really has a place hold on what and how much capital you can spend in a fiscal year.

MS. RIGGOTT: Thank you.

MR. DAVID FERNANDES: Hello. My name is

David Fernandes. I'm part of the OHCA staff. My questions will pertain to the intercompany system fees, and my first question is going to be would it be accurate to say that the incremental column within the financial Worksheet A, as submitted in the pre-filed testimony, does not include the Trinity Health New England intercompany fees?

MS. SCHNEIDER: Jennifer Schneider. With respect to the intercompany fees, there's a couple of different components, and the first is the system allocation, which is -- I think you've seen us reference it. It's a .8 percent of total operating expenses.

When we show the incremental savings of one percent, that was net of the 1.8, so those types of corporate fees really are to support all the things we've talked about here, evidence-based standards as we move forward, and it really gives the ministries access to those services and really that benefit.

There's another piece, as you see reference in the definitive agreement and other places in the submission, where it talks about shared services.

In those shared services, really we tap into those. They're more direct expenses, so once we start utilizing revenue cycle and other areas directly,

it's really, again, a one-for-one, so there's no incremental costs associated with either Trinity Health New England or Saint Mary's with respect to those, and those come on later, as we become more mature into Trinity Health and Trinity Health New England as the organizations move forward.

MR. FERNANDES: Thank you. My second question is can the Applicants at this time provide an estimated dollar amount for what the intercompany fee might be after the first year of the proposal?

MS. SCHNEIDER: So the intercompany fee, again, is the .8 percent of operating expenses, and it will be set at the Trinity Health New England level, so, you know, for Trinity Health New England, it will likely be about between eight and nine million for the entire system, and then it will be Trinity Health New England's responsibility to allocate that across all of the local hospitals and other entities within the organization.

MR. FERNANDES: Okay, thank you. Third question. Currently, what is Saint Mary's spending on the services that will now be covered by the intercompany fees?

MR. BITTNER: Well I think it's hard to quantify at this point, because there are certain I guess

operational costs that we just haven't been able to get to. Some of them are purposes for FTC reasons, but, as you look at Trinity's overall supply chain that Chad Wable had just mentioned, in terms of changing group purchasing organizations and having a group purchasing organization the size that Trinity Health has, bring supply chain savings to Saint Mary's, specifically, but, also, to Trinity Health New England.

In addition to that, they also maintain their own commercial insurance programs. Not only commercial insurance, but for property, casualty, general liability, malpractice. All those costs are self-insured by Trinity Health.

There's 90 hospitals with over $15 billion or $16 billion in revenue, so given that scope in size, so insurance costs related to Saint Mary's, supply chain costs, also treasury costs, when you start looking at cost of capital, the amount of investment return that one could have, when you're in a position like Trinity Health has been, St. Francis Care and Saint Mary's, as well, where you're subject to debt covenants around certain days cash on hand, you don't really have the luxury to invest a lot of your cash into the open market, because it doesn't -- it can't really suffice with the swings in

the market, so if you have an unrealized loss, it can put you in a position where now you no longer meet those covenants.

And, so, with Trinity Health, they actually put, they can actually put those investments in the market and earn an additional return, so it's not only a savings on expense perspective, but, also, it's beneficial interest or investment income that can be generated from the cash that's currently on hand at the respective organizations.

MR. FERNANDES: Thank you. My last question will be, other than the intercompany system fees, will Saint Mary's be required to make any other payment, either directly or indirectly, through the New England Regional Health Ministry to Trinity Health, Inc.?

MR. BITTNER: Well, at this time, there's no fees that I can tell you today that would occur and how some of those could change in the future.

I do think that, as we bring the region together, there will be shared services across the whole region, so there will be regional costs that will be held at Hartford, so revenue excellence, a revenue cycle, for instance.

What we're trying to work on is developing

a unified billing office, so if you're a patient, wherever you had gone within Trinity Health New England, you would get one patient bill for any service provided by any clinician, who is affiliated with our system, would go through a unified billing office, and that patient, then, is connected throughout the entire region through the electronic medical record.

So with that aspect, some of those services are corporate services, and those fees, then, would be charged up through the individual hospitals that they belong to, so Saint Mary's could have a regional fee, if you will, but all those fees would just be offset by the overhead cost reductions as the system kind of matures and achieves and climbs the scale throughout the region.

MR. FERNANDES: The billing service, is that included right now in the .08 percent?

MR. BITTNER: No, it's not.

MR. FERNANDES: So it potentially may be an increase, or there may be a potential like --

MR. BITTNER: There may be a price that goes, maybe a cost over to the regional system, but if you look at the cost currently for Saint Mary's to provide billing services, that actual cost would go down.

It would just be, instead of spending it on FTEs within the local area, it would be in a regional setting, so, actually, a reduction in the overall cost, itself, but it stays within the region.

MR. FERNANDES: Okay, thank you. That concludes my questions.

MR. RONALD CIESONES: Ron Ciesones, OHCA staff. My questions are going to start regarding some of the accounting methods and the financial stability of the organizations. They come from the interrogatories that were filed.

Regarding the statement of operations data for the first six months that were submitted with the pre-file, do you expect the financial performance would be similar in the second half of the year as with the first six months of activity?

MR. BITTNER: The short answer is, no, no. We expect operations to improve. September of 2015, the health system, both our health systems, actually, was really hit with the first kind of round of Governor Malloy's reductions and really forced us, and we at St. Francis Care had a budget ready to go in front of our Finance Committee.

We actually kind of tossed it. We kind of

restart the budget process over again, and that time that it took, basically, to respond to the reductions in reimbursement on the State and the Federal level I think took us at least that six months, and, as Chris has stated before and Chad, as well, what we've done is focus on productivity improvements, trying to look at the productivity of our staff, provide them tools and resources to better manage the staff and be able to flex up and down between where the volume is occurring with each of the patient floors.

That, and then working with Trinity Health to try to optimize some of the synergy, so it's taken us I think the first six months of the fiscal year to get in line a lot of those operating improvements and get in line some of the strategic initiatives that we wanted to put in place to make those improvements into the fiscal year, so that six months ending March we actually had significant improvements in our fiscal situation, were, actually, we had a $3 million gain as Trinity Health New England and then moving forward in the April, May, June, which completes the fiscal year for Trinity Health.

We expect the latter six months to improve significantly, and we're hopeful that we'll get the funding that the legislative body just approved in this

last special session back in December and, again, in May.

MR. CIESONES: Now your response is mostly regarding Trinity Health New England's piece, as to the finances?

MR. BITTNER: Yeah.

MR. BECKER: Ralph Becker. We are doing a little bit better this year than we have been. Volumes are up a little bit, so that's been helping, but do I see us doing as well in the last six months? Yes. I think we will continue doing as well as we are right now, again, subject to what happens with the provider techs.

MR. CIESONES: So would you say that the financial ?? that were submitted with the application would be accurate for the years 2017, '18 and '19, or would they need to be adjusted?

MR. BITTNER: That's our best estimate today. I think that assumes that we get some of the tax funding back that have been promised in the legislature, so, again, if the administration withholds the supplemental payments, so, for Hartford, for St. Francis, that's $40 million of taxes that we pay, so whatever supplemental payments we don't get, that kind of goes back into the overall tax, itself.

This assumes that we get at least what's

been estimated by the legislature, and it's our best estimate at this point in time.

MR. CIESONES: Throughout the application or the pre-file, rather, you, on pages 1025 and 1034, you reference cash flow from operations quite a few times for both St. Francis and Saint Mary's.

How come you use -- is there a reason that you use cash flow from operations, as opposed to operating income and losses from the statement of operations?

MR. BITTNER: Yeah, because the cash flow from operations kind of, before we actually make any kind of capital expenditures, so that's basically what the organizations bring in from a cash perspective before we actually expend it in other capital or other investments, so that's the indication of what we can generate just from an overall cash flow perspective.

MR. CIESONES: And would you be able to provide a supporting worksheet for the numbers that you have on both pages 1025 and 1034 for both St. Francis and Saint Mary's?

MS. SCHNEIDER: Jennifer Schneider. So you're just looking for supporting documentation to support those numbers?

MR. CIESONES: Right. There's St. Francis, 33.6 million.

MS. SCHNEIDER: We could provide that.

MR. CIESONES: Okay, thanks.

HEARING OFFICER HANSTED: Okay. I'll order that as Late File No. 1.

MR. CIESONES: My next question regards Saint Mary's pensions. That's noted throughout the pre-file. You noted that one of the -- once this was to go through, that you would like to bring the Saint Mary's pensions more -- fund more of the pensions, similar to Trinity. Do you have any procedures, methods to do that?

MR. BITTNER: I think there's an overall, I guess, philosophy, and that philosophy would be to fund it at the same levels as you mentioned before.

There's a lot of information that goes, a lot of variability that goes into that calculation, itself, so a discount rate, for example, so if you look at the current interest rate environment that we're in, it has a lot to do with what the overall pension obligation is going to be out in the future, so it has a huge impact on what the funding status is, so if you had a one percent increase in the discount rate, you could have an increase of funding status significantly just

from that one change in interest rate environments.

The second one is some of the demographic information related to the assumptions being used in the actuarial valuation, so a lot of those were just recently changed, both for Saint Mary's and organizations, I think, in the United States, actually, that has a significant impact on the overall pension obligation, how much that is.

The other piece is how well is the investments in the pensions doing within the market, itself. So if the market does significantly better than what your expectations are, then your funding status automatically goes up, without any additional contributions.

I guess, aside from that, there is an overall plan. Historically, Hartford has always funded the pension expense, and, so, that would be more of a minimum funding requirement from a personal perspective or how we kind of treat that historically, but anything above that we'd like to get to that 80 percent, plus, 80, 85 percent level of funding status, where, currently, at the end of FY '15, Saint Mary's was at 47 and a half percent.

And, so, that's both a combination of

change in discount rate, change in looking at the actual how the investment performance is doing, as well as contributions by Trinity Health, Trinity Health New England into the actual pension plan, itself.

MR. CIESONES: Do you see Trinity somehow taking a loan to bump up the funded status possibly?

MR. BITTNER: Possibly. That's always an option. That is one of which we're looking for with Trinity Health New England. With St. Francis Care, we're looking at a loan to help continue to fund our pension liability into the future, as well.

MR. CIESONES: The next couple of questions I have are regarding the capital commitment amounts for Trinity Health New England.

On page 1034, the previous responses indicate that the hospital spends roughly $12 million per year on capital expenditures or capital acquisitions, and Saint Mary's Health System projects to earn approximately 8 million per year from operations after the merger.

Why does -- considering that there will be a profit from operations, why does Trinity have to contribute the 54.7 million for Saint Mary's?

MR. BITTNER: A big portion, I think, of that, the $45.3 million is over a series of time, so,

over the five-year period, it's expected that there will be an operating income, which is that 45.3, so there's a $100 million commitment. The difference, then, is that 54.7, so what's hard to predict, in terms of either whether we forecast something two years out or three years out, is what's going to happen on a federal and state reimbursement perspective?

It's hard to predict, and I think, to a certain degree, as we try to even budget for even this year and last year, St. Francis I can speak for had made commitments to its employees to increase its across the board living adjustments.

We make commitments to fund defined contribution plans, of which, because of the promises that were made around the supplemental payments and the supplemental pools around the provider tax, itself, we made those commitments, but, then, once those were pooled, we still honored those commitments, knowing that there may be opportunities where the legislature comes back, and I think in this case, as well, I just look at the 45.3 million, some of the 54 that's got to be funded through intercompany debt is because it's anticipated that there are going to be issues, I think, on the state side, as well, and federal reimbursement, for that

matter.

MR. CIESONES: Also, on page 1034, will the operating losses that thus far in fiscal year 2016 for Trinity affect the funding for St. Francis' $158 million contribution from operating income from the same chart?

MR. BITTNER: Could you repeat that?

MR. CIESONES: On the chart, you have 158 million for St. Francis.

MR. BITTNER: In expected operating.

MR. CIESONES: Right.

MR. BITTNER: Right.

MR. CIESONES: On the financials that you submitted with the pre-file for the first six months shows Trinity Health with an operating loss of roughly 16 million?

MR. BITTNER: Right.

MR. CIESONES: Will that affect the $158 million commitment, the commitment that comes from operating?

MR. BITTNER: No. So, first of all, I'll just kind of mention, when St. Francis and Trinity Health got together, there was a $275 million kind of commitment over a five-year period of time.

You kind of see the breakout is 1,033, how we're looking at that 275 million amongst, and it has given us opportunities with Saint Mary's, Johnson Memorial Medical Center to kind of come together in this regional health system, so if Hartford, if St. Francis Care does not perform financially, then more money, then, would come from Trinity Health, in order to fund that commitment versus the funding of the commitment coming through hospital operations through income from operations.

I don't expect -- I think the 158 million is our best estimate of what our cash flow income is going to be over the next five years, considering what's happened with reimbursement, and that's kind of our best guesstimate.

It wouldn't impact, then, if we had losses, it may impact where we'd get more money from Trinity. If we got higher, the less money that we have to borrow from Trinity from a capital commitment perspective.

MR. CIESONES: I just have one last question. Would the operating revenues from one of the hospitals, whether it's Johnson or Saint Mary's, be used to fund capital improvements at another regional health

ministry hospital?

MR. BITTNER: Within Trinity Health New England? Are you asking if it could?

MR. CIESONES: Yes.

MR. BITTNER: Yes, it could.

MR. CIESONES: So money can kind of flow in between the three hospitals?

MR. BITTNER: Yeah. If one hospital is much more successful than another hospital, then definitely, if there's a need from a community perspective, then that hospital would have the funding it needs to support those programs and services, and one of the pillars I think Trinity Health has and Trinity Health New England is commitment to those, who are poor, and, so if one hospital is struggling to fulfill that commitment and the other one is doing very, very well, then some of that operating income would go to actually improve the other's performance and continue those other services.

MR. CIESONES: So the three will kind of all be working together?

MR. DADLEZ: Well you're seeing that right now, for example, at Johnson Memorial. We're providing substantial support to Johnson right now while it's getting its feet on the ground and restructured, so,

obviously, that has to happen.

When we're trying to do is evolve from this old school hospital enterprise to a total health care operating company that's responsible for developing the right services in the right place at the right time for the entire region, so we'll be investing in ambulatory care development that might be between Hartford and Waterbury. We'll be investing in ambulatory development between ourselves and Johnson Memorial.

So the whole world is changing, and how we invest our dollars is really focused at how do we create the best system we can for the people that we serve?

And, so, it will be somewhat fungible, but we want to take care of the locations, because the hospitals right now, you know, they have to be successful and drive a lot of business, but we're trying to evolve in this case, and capital investment is going to depend on how the whole health care enterprise evolves, if that makes sense.

MR. CIESONES: That's all I have for questions.

HEARING OFFICER HANSTED: Before OHCA continues with its questions, I understand we have a senator that would like to give public comment.

(Whereupon, Joan Hartley gave public comment.)

MS. SCHAEFFER-HELMECKI: Hi. Good afternoon. So I'd like to ask a few more questions about the capital commitment and, specifically, how you expect it to be apportioned among the different regional health ministry entities.

And, as a basic question, firstly, are the amounts of capital expenditure allotted to each hospital maximums or minimums?

MR. BITTNER: Minimums.

MS. SCHAEFFER-HELMECKI: Now during the public hearing associated with St. Francis' application, 15-31979-CON, Trinity stated that at least 195 million of the $275 million pool of capital expenditures would be committed to St. Francis Hospital, specifically. Is that correct? I believe it was actually your testimony, Ms. Schneider.

MS. SCHNEIDER: Well I have to locate it.

MS. SCHAEFFER-HELMECKI: It was on page 33 of the transcript. I believe it was the portion that we took administrative notice of.

MS. SCHNEIDER: That's correct. So if you note there, it says 195, specific to St. Francis Hospital

capital acquisitions, whether it's upgrade to facilities, medical appointment, other areas that have been identified.

And I think, when we speak about, you know, the upgrades and the capital acquisitions, that can be inclusive of the St. Francis system.

MS. SCHAEFFER-HELMECKI: Okay and I believe you later said that it was specifically for entities already affiliated with St. Francis on that July 1, 2015 hearing, although there was 48 million allocated for other future associations.

MS. SCHNEIDER: Correct. That is correct.

MS. SCHAEFFER-HELMECKI: Great. So, in your responses to the completeness questions, you also stated that, at the time of the St. Francis hearing, again, July 1st, that you knew Trinity and Saint Mary's would seek to merge.

That being said, why has St. Francis' capital commitment been reduced from 195 million to possibly 142 million?

MS. SCHNEIDER: So I think, again, to David's point earlier, it's the minimum capital commitment, and I think it's really the 162 million is specifically a minimum to St. Francis. Oh, sorry. Page

1034.

MS. SCHAEFFER-HELMECKI: Excuse me. What was that on page 1034?

MS. SCHNEIDER: 1034, up at the top, the total capital expenditures, total funding. We were asked, I think, to show, to demonstrate how the 275 could be allocated, and we talk about the 100 million minimum to Saint Mary's, 13 million to Johnson, and 162 million to St. Francis, and, again, these are the minimums.

MS. SCHAEFFER-HELMECKI: Maybe I misunderstood, but I thought that was the source of the funding, where the money was coming from, not where the money was going on page 1034, so are you referencing 1033?

MS. SCHNEIDER: Correct. Which rolls over to 1034.

MR. BITTNER: Let me just mention, so, when Trinity Health and St. Francis Care came together, it formed Trinity Health New England, and, so, a $275 million capital commitment went to Trinity Health New England, of which then it's utilized to that capital commitment to help with the acquisition of Johnson Memorial Medical Center on January 1, 2016, and then now, as Saint Mary's have come together, it's provided the

necessary capital to provide a commitment.

St. Francis Care on its own wouldn't have the ability to be able to commit those kind of funds without a partner like Trinity Health, so that 275 was at Trinity Health, so St. Francis Care on October 1st became Trinity Health New England.

MS. SCHAEFFER-HELMECKI: So you're saying there was no money allocated to a specific entity, and you're saying it was just a general pool of 275, and the allocation that was submitted as part of the application was not indicative of how the money was actually to be spent?

MR. BITTNER: No. The 275 was allocated to Hartford within Trinity Health. It formed Trinity Health New England, so Trinity New England then became the entity in which, for the Hartford office, then, of which it could spend or have commitments of that 275 million over a five-year period of time.

MS. SCHAEFFER-HELMECKI: But at the time of the application, St. Francis Hospital was St. Francis Hospital, so references to money allocated to St. Francis Hospital was the hospital and not St. Francis Care or what is now the Regional Health Ministry, correct?

MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, great. All right, so, just to return to that $48 million, that was unallocated originally, so, at the time, you did state that you believe that Johnson's capital expenditures would probably come out of that 48 million, as it was an organizational priority, correct?

MS. SCHNEIDER: That is correct.

MS. SCHAEFFER-HELMECKI: And then, also, you stated that St. Francis, so, like you anticipated the Saint Mary's merger, and I still am not seeing exactly why there wasn't money allocated in that 48 million for Saint Mary's, because now we're looking at a capital expenditure for other entities of between 113 million and 133 million, which that seems like a fairly significant departure from the 48 million that you had set aside originally, so I don't understand. I guess I'm not seeing why there wasn't more money set aside.

MS. SCHNEIDER: I think, at that point, it was really the timing and where we were in the maturity of the discussions with Saint Mary's, in terms of being able to specifically allocate anything at that point in time.

MS. SCHAEFFER-HELMECKI: So now the change in the Saint Francis, excuse me, Saint Francis Hospital

allocation is about between 65 and 85 million difference than what was initially projected to be spent on capital there.

What projects, if any, will be eliminated or modified at St. Francis as a result of that change?

MS. SCHNEIDER: I think, going back to David's point around our capital strategy, we really look at three years. We try to plan three years. It's even difficult, so there's nothing that we're aware of that would not happen.

And, again, this is the minimum commitment, as we continue to identify strategic initiatives and necessities within the local hospitals that are part of the ministry.

Those would be our priorities, and if we needed access to capital, we would, then, move forward as part of the capital management process within Trinity and see if we could get funding for those if our operating income and our current cash flows could not support that, but there's nothing, I think at this point, that I'm aware of that would be delayed or not fulfilled, based on any of these changes, specific to St. Francis Hospital.

MS. SCHAEFFER-HELMECKI: And at what point would you know what the capital expenditure plan is at

St. Francis if anything is changing?

MS. SCHNEIDER: So we are in the process of doing our capital budget right now for fiscal '17, which we will manage and report I think as of July 1 fiscal year, and, at this point, everything that's included in our capital plan is going to, you know, Trinity Health for insurance.

It's aligned with the strategy, and we would hear, and we don't believe, and we've heard nothing to lead us to believe that that wouldn't continue to be our plan for fiscal '16. '17.

MS. SCHAEFFER-HELMECKI: So, now, if there are any additional entities that are acquired by Trinity in the future that become part of the Regional Health Ministry, would that in any way alter the amount available to Saint Mary's for capital expenditures?

MR. BITTNER: I think that the 100 million or 120 million, depending on how Saint Mary's performs, there may be opportunities that Saint Mary's finds within the community within Waterbury for investment opportunities that may go against that $100 million.

So, if you look at their current operations now, there's a lot more investments that have to occur, I think, in the future, whether that's the

acquisition of ambulatory strategies ?? the community.

That could further -- I mean that's an investment of capital, right? So that goes against the $100 million, I guess you'd say, if it's related to the ambulatory strategy around the Waterbury market.

So I think, from a capital perspective, we tend to look at this from a more global perspective around Trinity Health New England and the region and how we provide health care services around the region, as well.

I can say that, as we mentioned before, these are minimum requirements, so if there's opportunities within the state, within the region that are good opportunities from an economic perspective, that those would be funded by Trinity Health, but those go to a separate Board at Trinity Health or a separate committee, of which Chris sits on, as well, that helps to allocate the overall resources that Trinity Health has from an investment perspective.

MS. SCHAEFFER-HELMECKI: So that's a, yes, it could change, but it's a minimum? You're saying that 100 million is an absolute floor, and regardless of any entities acquired in the next five years, there's a guaranteed $100 million commitment?

MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, thank you. Okay, I have just one last set of questions. Prior to Trinity's acquisition of St. Francis, how much was St. Francis spending each year on average on capital investments.

MS. SCHNEIDER: Between 35 and 38 million on average prior to. The more recent years were a little bit higher with our investment in the Epic implementation, so prior to those two years, it's probably closer to 30 million, but, more recently, about 35 to 38.

MS. SCHAEFFER-HELMECKI: Yeah. I think we had 39, the number that had been stated several times, so that seems accurate.

Based on your projections of spending between 142 and 162 million in capital at St. Francis over the next five years, that works out to an average of between 20.4 million and 32.4 million per year.

Are you projecting a decline in capital spending at St. Francis compared to its spending prior to joining Trinity?

MS. SCHNEIDER: No. Again, that would be the minimum, and the budget currently, going into fiscal

'17, is just under 40 million as it stands today. Again, there's a lot of regulatory pressures and other financial issues we're dealing with, so it's not approved yet, but it's higher.

MR. DADLEZ: An example of that is, because we keep stressing minimum, minimum, I mean this is the bottom threshold, in the Springfield market, for example, which doesn't deal with Connecticut, Trinity just funded the purchase of a 200-member physician group, River Bend Physician Group in that region, and over and above, way over and above the capital commitments that is made on an annual basis to assistance of Providence health system, so the commitment is to do what's right for the community, and if there are opportunities to develop and grow, Trinity's commitment is to fund that.

We're very quickly becoming one of the largest, if not the largest regional ministry in the nation, and they want us to grow and develop.

The intent is for us not to squeeze dollars out of this region, but to strategically grow it and make it stronger, so I frankly and firmly believe that there's a commitment to do more, not less, so, in my mind, there's no way that it will be less than what we've traditionally spent.

MS. SCHAEFFER-HELMECKI: Okay, great. Thank you.

MR. DADLEZ: Okay.

HEARING OFFICER HANSTED: All set? Okay. That concludes OHCA's questioning.

At this point, I want to ask one more time is there anybody here that would like to give public comment that has not had an opportunity to do so?

I don't hear or see anyone. It's only 5:30 at this point. What I'd like to do is give members of the public an opportunity to get out of work and actually travel here, if they choose to do so, so we will adjourn until 6:00 p.m.

At that time, we'll go back on the record to see if there's any more public comment, so, at this point, we're adjourned until 6:00 p.m.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're back on the record. It's now 6:00 p.m. One last time, is there anybody here that would like to give public comment on the proposal before us?

Hearing and seeing none, I would like to thank everyone for attending, and this hearing is adjourned.

(Whereupon, the hearing adjourned at 6:00 p.m.)

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CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 18th day of May, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, May 17, 2016 8:09 AM
To: Hansted, Kevin; Riggott, Kaila; Fernandes, David; Ciesones, Ron
Cc: Greer, Leslie; User, OHCA
Subject: FW: 15-32045-CON Saint Mary's Late File
Attachments: Late File DN 15-32045-CON.pdf; 15-32045 Late File Last 12 months EBIDA.xlsx; 15-32045 Late File St Mary proj cash flow.xlsx

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From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Monday, May 16, 2016 1:28 PM
To: Schaeffer-Helmecki, Jessica
Cc: Hartley, Christopher; Rotavera, Liz; Attorney Bob Anthony; Joseph Connolly - St. Mary's Hospital (jconnolly@stmh.org); Schneider, Jennifer
Subject: 15-32045-CON Saint Mary's Late File

Hello Jessica…Attached are pdf and excel documents in response to the late file request from the Saint Mary's and Trinity Health – New England May 10th public hearing.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

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Trinity Health - New England
15-32045 Late File
Last Twelve months EBIDA Calculation (Cash Flow from Operations)

Saint Francis/Trinity Health - New England

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Last 12 Months
Total Net Revenue	70,908	68,835	67,628	73,123	65,819	66,555	70,731	67,707	70,228	71,812	63,916	81,047	
Operating Income	1,943	664	(3,149)	3,583	(1,341)	(5,335)	(37)	(4,928)	(4,938)	(4,977)	(4,540)	2,908	
Excess Rev over Exp	2,349	1,499	7,607	3,847	(2,439)	(15,682)	(2,748)	(4,132)	(5,365)	(4,675)	(5,120)	5,212	
EBIDA	6,057	4,898	1,093	7,827	2,883	(1,012)	4,107	(733)	(816)	(598)	(362)	10,208	**$ 33,552**
EBIDA Margin	8.54%	7.12%	1.62%	10.70%	4.38%	-1.52%	5.81%	-1.08%	-1.16%	-0.83%	-0.57%	12.60%	

Saint Mary's

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	
Total Net Revenue	25,399	24,762	26,024	23,996	22,395	22,894	25,030	23,818	25,404	26,825	27,089	28,303	
Operating Income	539	283	1,500	(859)	(1,052)	(358)	(594)	(443)	1,637	925	203	1,967	
Excess Rev over Exp	578	519	1,846	(386)	(550)	(1,646)	(631)	(492)	2,404	772	339	1,807	
EBIDA	1,608	1,278	2,361	151	(26)	869	416	615	2,714	1,960	1,239	2,985	**$ 16,172**
EBIDA Margin	6.33%	5.16%	9.07%	0.63%	-0.12%	3.80%	1.66%	2.58%	10.68%	7.31%	4.57%	10.55%	

Total

Source: internal financial statements.

Saint Mary's Health System
Future Cash Flows for Capital Acquisition after Debt Service
15-32045 Late File

	(4) FY 2016 Projected With CON	(7) FY 2017 Projected With CON	(10) FY 2018 Projected With CON
Per Worksheet A Page 1012 of CON EBIDA	**$16,299** **5.4%**	**$18,755** **6.0%**	**$21,087** **6.6%**
Less: Principle Payments (Line 33 of worksheet A)	$3,000	$3,000	$3,000
Cash available for Capital Acquisition after debt payments	**$13,299**	**$15,755**	**$18,087**
Amounts reported on page 1025 of CON	**$13.3**	**$15.6**	**$18.1**

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Wednesday, June 01, 2016 8:53 AM
To: Attorney Bob Anthony; Hartley, Christopher
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: 15-32045 Close of Hearing
Attachments: 15-32045 Close of Hearing signed.pdf

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 1, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry
Closure of Public Hearing

Dear Mr. Hartley and Mr. Anthony:

Please be advised, by way of this letter, the public hearing held on May 9, 2016, in the above referenced matter is hereby closed as of June 1, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Jessica Schaeffer-Helmecki at (860) 509-8075, Ronald Ciesones at (860) 418-7030, or David Fernandes at (860) 418-7032.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH:jssh

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Wednesday, June 01, 2016 8:54 AM
To: Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: RE: 15-32045 Close of Hearing

Thank you for your help in this important endeavor.

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Wednesday, June 01, 2016 8:53 AM
To: Attorney Bob Anthony; Hartley, Christopher
Cc: Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
Subject: 15-32045 Close of Hearing

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
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Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, July 27, 2016 4:08 PM
To: 'BAnthony@Stmh.org'; Hartley, Christopher (CHartley@stfranciscare.org)
Cc: Schaeffer-Helmecki, Jessica; Fernandes, David; Ciesones, Ron; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: DN: 15-32045-CON Agreed Settlement
Attachments: 32045 Agreed Settlement.pdf

Attached is the Agreed Settlement for DN: 15-32045-CON.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants:

Saint Mary's Health System, Inc.
56 Franklin Street
Waterbury, CT 06706

Trinity Health Corporation
20555 Victor Parkway
Livonia, MI 48152

Trinity Health–New England, Inc.
114 Woodland Street
Hartford, CT 06105

Docket Number: **15-32045-CON**

Project Title: **Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health–New England**

Project Description: Saint Mary's Health System, Inc. ("SMHS"), Trinity Health-New England, Inc. ("TH-NE") and Trinity Health Corporation ("THC"), herein collectively referred to as the ("Applicants"), seek authorization to transfer ownership of SMHS and its subsidiaries to THC and TH-NE.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the *Republican American* (Waterbury) on October 22, 23 and 24, 2015. On November 25, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on April 5, 2016.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

On April 18, 2016, the Applicants were notified of the date, time, and place of the public hearing. On April 20, 2016, a notice to the public announcing the hearing was published in the *Republican American*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on May 9, 2016.

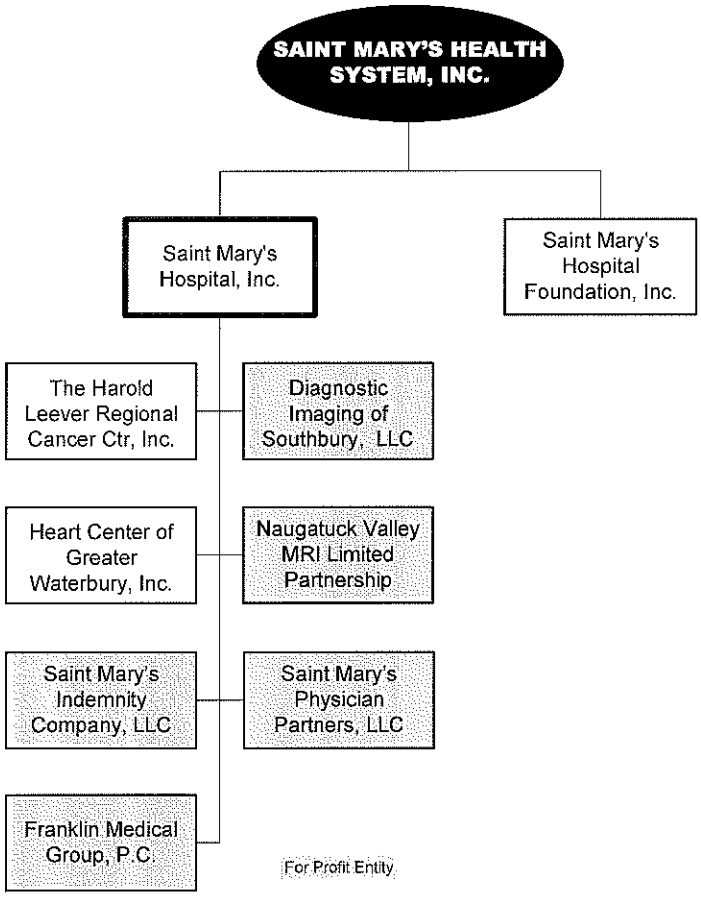
Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a.

The record was closed on June 1, 2016. Deputy Commissioner Addo considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. SMHS is a not-for profit, integrated Catholic health care delivery system serving the greater Waterbury area. Ex. A, p. 18.

2. SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliated entities (see legal chart of corporate structure, below). Department of Public Health, Office of Health Care Access, 2015, *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2015*; Appendix AA.



3. The Hospital is a 347-bed Catholic acute care hospital. It is designated as a Level II Trauma Center and provides a full range of inpatient, outpatient and ancillary services to residents of Waterbury and surrounding towns. Ex. A, p. 18.

4. The Hospital's primary service area is comprised of 16 towns. The Hospital's service area will remain the same as a result of this proposal. Over half of all inpatients in fiscal year (FY) 2015 were Waterbury residents (see table below).

TABLE 1
SAINT MARY'S HOSPITAL FY2015
PRIMARY SERVICE AREA TOWNS

Primary Service Area	
Town*	**Discharges (FY 2014)**
Waterbury	58.75%
Naugatuck	9.18%
Wolcott	6.25%
Prospect	3.34%
Total	**77.52%**

*Listed in descending order of discharge volume.
Ex. A, pp. 32-33; Ex. A, p. 289.

5. In anticipation of health care industry changes and federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to an accountable care organizations ("ACO") focused on population health management. SMHS determined that a strategic partner would bolster its ability to effectuate its Strategic Plan. Ex. A, pp. 22-23.

6. The need to address the following factors also prompted the Hospital to seek a partnership with another health care system:
   - Increased costs associated with quality improvements,
   - The growth of physician partnerships and the need for additional expertise in the management, staffing, data analysis and clinical oversight of a larger physician enterprise,
   - Necessity of expertise in clinical service redesign to utilize the latest clinical techniques,
   - SMHS's intent to expand upon its integrated accountable care organization
   - The financial capital required to meet the medicals records standard of the Patient Protection and Affordable Care Act ("PPACA"),
   - Development of a plan to address pension and other debt obligations, and
   - An aging infrastructure and the need to provide health services to the community as reflected in the Community Health Needs Assessment ("CHNA").

   Ex. A, pp. 22-24; Ex. E, p. 874; Ex. L, pp. 1026-1032.

7. SMHS created the SMHS Board-Appointed Taskforce ("Taskforce") more than a decade ago to assess potential partners based on a set of criteria including each candidates philosophical principles and adherence to a complementary set of religious directives; financial strength and ability to assist in satisfying SMHS's pension liability; provision of resources to improve technology at SMHS; and opportunities to recruit and retain staff. Ex. A, pp. 26-27; Ex. L, Prefile Testimony of Robert Mazaika, Chairman of the Board, SMHS, pp. 1062-3.

8. SMHS found THC and TH-NE to have a strategic plan and values very similar to its own, while sharing a common vision, philosophy and mission that preserves the Catholic health care tradition. Ex. A, pp. 22-23; 27.

9. Following the recommendation of the Taskforce, SMHS's full board approved a strategic alliance and a membership transfer agreement was signed on September 19, 2015. Ex. A, pp. 22-23; 27.

10. As a result of this agreement, the Applicants are requesting approval to transfer ownership of the Hospital and its subsidiaries to THC in order to become part of TH-NE. Ex. A, pp. 20, 27.

11. THC is a Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs across 21 states. It is the sole shareholder of TH-NE. Ex. A, p. 19.

12. TH-NE is the parent company of other health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford. Docket Number 15-31979-CON. Ex. A, p. 19.

13. The focus of TH-NE's organizational structure is to create a system that meets PPACA's objectives of improving population health, enhancing the patient care experience and controlling cost, while maintaining a positive financial margin. Ex. A, p. 24.

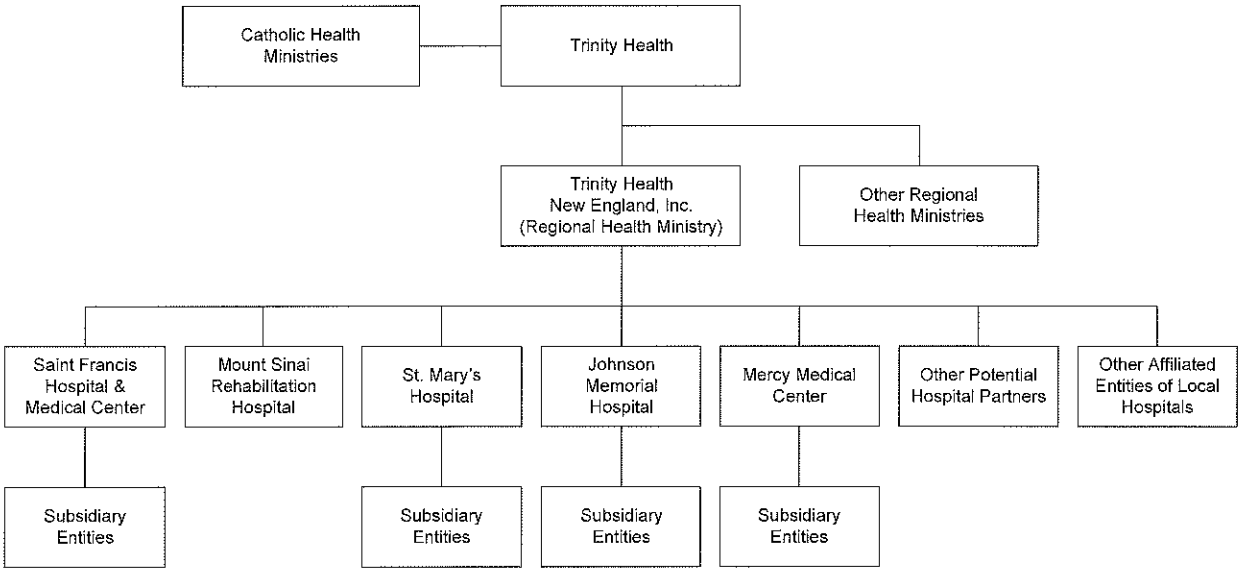
14. THC's key growth initiatives aim to align with organizations to strengthen the Catholic health care mission and to expand the system "footprint" to create an integrated ACO in each of its markets. Ex. A, p. 20.

15. THC has established a Unified Clinician Organization ("UCO"), a data and evidence-based infrastructure to align and support clinicians across the THC system, in an effort to advance a culture of safety, best practices, quality, patient satisfaction and high reliability. THC's accomplishments as a result of implementing its UCO initiatives include:
    - Decrease in sepsis mortality rate from 15.8% to 11.2% between FY 2010 and December 2014, resulting in 2,328 saved lives;
    - Elimination of vaginal birth after cesarean section "serious reportable events" following 2009 policy implementation;
    - Decrease in elective deliveries before 39 weeks from 4.7% from 2010 to 0.5% in 2015;
    - Consistent medication reconciliation composite score (both admission and discharge data) of 88% in FY 2015 to date;
    - Decline in pressure ulcer rates from 3.8% in FY 2008 to 0.01% in January 2015;
    - Lower than expected severity adjusted mortality rate (83%) in FY 2015;
    - Elimination of retained sponges in FY 2014 post-sponge accounting implementation; and
    - Improvement in safety checklist perfect patient score from 48% in January 2013 to 81% in July 2014.

    Ex. A, pp. 44-46.

16. To combat the substantial costs of hospital readmission, THC developed a post-acute care affiliated network that links a hospital to the continuum of post-acute providers. The result was a more accurate and efficient transition of patients from the hospital to the next level of care reducing readmission. Ex. A, pp. 52-53.

17. It is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. The following illustration depicts the organizational chart of the Applicants following the proposed transaction.



Ex. A, p. 163; Ex. E, p. 865.

18. SMHS's existing Bylaws and Certificate of Incorporation will be amended and restated so that TH-NE is the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. Ex. A, pp. 20, 112.

19. The Applicants propose adding two board members, appointed by THC for a period of three years to the TH-NE Board of Directors. The Hospital's governing board will remain unchanged other than the addition of the CEO of TH-NE. The governing board of the Hospital will be comprised of:
    - A representative of the member, designated by the member;
    - At least one physician; and
    - Members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community.

    Ex. A, pp. 20-21; 70-71; 113; Ex. E, pp. 900-901.

20. The Hospital's board will have community representation that will have the ability to pass on quality concerns and local community health needs to the regional governing board. Testimony of Mr. Dadlez, Ex. N, pp. 40-41.

21. There are no planned changes to the clinical services or location of any clinical services currently being offered by the Hospital. However, following implementation of the proposal, an "efficiency analysis" will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize the processes. Ex. A, pp. 21-22; Ex. E, p. 875.

22. For three years following implementation of the proposal, the existing SMHS Board's approval will be required prior to the termination or material reduction of any existing clinical services. Ex. A, p. 16.

23. The proposal does not involve any new equipment. There is no capital cost associated with the Transfer Agreement between the Applicants. Ex. A, pp. 21-22; Ex. E, p. 875.

24. The affiliation with TH-NE is intended to allow the Hospital to access experts in all clinical service lines and support platforms, and enhance its service delivery approach and systems. Ex. A, p.41.

25. The partnership between the Hospital and THC is also expected to result in access to resources of a large system at both the regional and national levels which will:
    - Help develop more preventive and primary care service programs, the need for which is identified in the 2014 CHNA;
    - Meet the demands of the 2010 PPACA, which requires an emphasis on value rather than volume in terms of reimbursement;
    - Provide access to readily available capital and financing at favorable interest rates; and
    - Assist in developing a plan to adequately fund SMHS's pension plan obligations. Ex. A, pp. 24-25.

26. The Health Resources and Services Administration has designated Central Waterbury as a medically underserved area and medically underserved population. Ex. A, p. 35.

27. TH-NE's CHNA and Strategic Implementation Plan ("SIP"), to be published in June 2016 and November 2016, respectively, will integrate the community health care priorities and strategies identified in SMHS's current CHNA. Ex. A, pp. 80-81; Ex. L, pp. 1031-1032.

28. The CHNA, developed by SMHS in conjunction with the Greater Waterbury Health Improvement Partnership, identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement for the Waterbury area. Greater Waterbury Health Improvement Partnership, *Community Health Needs Assessment Final Summary Report* 45 (Sept. 2013). Ex. A, p. 233.

29. To address chronic health conditions, THC will use community outreach to implement its Community Health and Well-Being Strategy, which emphasizes reducing the number of uninsured, recruiting multi-cultural and multi-lingual input from the community, prioritizing obesity prevention and tobacco control and transforming safety net care. The Hospital's current strategic focus area, in an effort to align its focus with that of the Connecticut Hospital Association, also addresses asthma in the community. Ex. L, p. 1030; Testimony of Mr. Connolly, Ex. N, pp. 23-25.

30. The SIP will follow the recommendations of the CHNA. Testimony of Mr. Connolly, Ex. N, p. 25.

31. The Hospital will be supported with resources in the form of regional and national experts to participate in national initiatives from the corporate headquarters of THC. Testimony of Mr. Dadlez, Ex. N, pp. 25-26.

32. SMHS currently leases space to Connecticut Children's Medical Center to provide inpatient services and the Hospital will continue to so following implementation of the proposal. Ex. A, pp. 39-40.

33. Following implementation of the proposal, TH-NE and Waterbury Hospital will work collaboratively to ensure the continued coordination of services provided by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury. Ex. E, p. 865.

34. Existing referrals patterns will remain unchanged. Ex. A, p. 57.

35. The Hospital will continue to operate for the benefit of the community and serve the poor and underserved, including supporting wellness, health education and other community programs, participating in medical research and governmental health care programs and identifying gaps in services in the community. Ex. A, p. 114.

36. The transfer of ownership will be complete by 10/1/2016. Ex. A, p. 70.

37. Overall volume for the Hospital fluctuated slightly from FY2012 through FY2015. Inpatient volume is projected to decrease .5% each year from FY2017 through FY2019 due to an expected continued shift of services performed as outpatient procedures.

TABLE 2
SAINT MARY'S HOSPITAL HISTORICAL DISCHARGES

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Medical/Surgical (Adult)	9,129	8,826	8,842	9,062
Maternity	1,021	977	1,066	1,070
Psychiatric	625	669	633	654
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	439	414	146	146
Newborn	864	843	955	913
Total	**12,078**	**11,729**	**11,642**	**11,845**

TABLE 3
SAINT MARY'S HOSPITAL HISTORICAL PATIENT DAYS

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015
Medical/Surgical (Adult)	41,395	41,900	40,663	40,360
Maternity	2,775	2,609	2,855	2,775
Psychiatric	3,994	4,099	3,933	4,139
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,390	1,303	1,240	1,227
Newborn	2,022	1,922	2,173	2,055
Total	**51,576**	**51,833**	**50,924**	**50,556**

TABLE 4
SAINT MARY'S HOSPITAL CURRENT & PROJECTED DISCHARGES BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Medical/Surgical (Adult)	9,114	9,055	8,996	8,937
Maternity	1,119	1,119	1,119	1,119
Psychiatric	600	600	600	600
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	146	146	146	146
Newborn	896	896	896	896
Total	**11,875**	**11,816**	**11,757**	**11,698**

TABLE 5
SAINT MARY'S HOSPITAL CURRENT & PROJECTED PATIENT DAYS BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2018
Medical/Surgical (Adult)	40,900	40,645	40,392	40,140
Maternity	2,914	2,914	2,914	2,914
Psychiatric	3,769	3,769	3,769	3,769
Rehabilitation	0	0	0	0
Pediatric	0	0	0	0
Neonatal ICU	1,220	1,220	1,220	1,220
Newborn	2,228	2,228	2,228	2,228
Total	**51,031**	**50,776**	**50,523**	**50,271**

Ex. A, pp. 71-75.

38. Medicaid is the primary payer for nearly a third of the patients served by the Hospital. The Applicants do not anticipate any significant changes in payer mix as a result of this proposal.

TABLE 6
SAINT MARY'S HOSPITAL CURRENT & PROJECTED PAYER MIX[1]

Payer	Most Recently Completed FY2015		Projected							
			FY2016		FY2017		FY2018		FY2019	
	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%	Discharges[2]	%
Medicare*	5,289	45%	5,313	45%	5,276	45%	5,240	45%	5,214	45%
Medicaid*	3,703	31%	3,696	31%	3,683	31%	3,671	31%	3,653	31%
CHAMPUS & TriCare	22	0%	22	0%	22	0%	22	0%	22	0%
Total Government	**9,014**	**76%**	**9,031**	**76%**	**8,981**	**76%**	**8,933**	**76%**	**8,888**	**76%**
Commercial Insurers*	2,601	22%	2,613	22%	2,604	22%	2,594	22%	2,581	22%
Uninsured	103	1%	102	1%	102	1%	101	1%	100	1%
Workers Compensation	129	1%	129	1%	129	1%	129	1%	128	1%
Total Non-Government	**2,833**	**24%**	**2,844**	**24%**	**2,835**	**24%**	**2,824**	**24%**	**2,810**	**24%**
Total Payer Mix	**11,847**	**100%**	**11,875**	**100%**	**11,816**	**100%**	**11,757**	**100%**	**11,698**	**100%**

*Includes managed care activity
[1] Fiscal year is October through September
[2] Volume equals equivalent discharges
Ex. A, p 63.

39. There will be no changes in services for indigent or Medicaid recipients. Ex. A, p. 48.

40. The Hospital's policies, procedures and guidelines on charity care and financial assistance policies will be reviewed to ensure compliance with the new Internal Revenue Code Section 501(r) requirements effective January 1, 2016. Ex. A, p. 82; Ex. E, p. 870.

41. The Hospital's charitable policies are consistent with those of both THC and TH-NE Ex. E, p. 870; Testimony of Mr. Hartley, Ex. N, p. 31.

42. Saint Mary's Hospital Foundation, Inc. will continue to be a separate endowed foundation supporting the Hospital and the Hospital's subsidiaries. The Hospital will continue to comply with existing donor restrictions of the Foundation. Ex. A, p. 17; 114.

43. The Hospital will retain all assets and property currently belonging to SMHS. Ex. A, p. 21.

44. There are no planned changes to existing reimbursement contracts or billing practices between the Applicants and payers as a result of this proposal. Ex. A, p. 83; Ex. E, p. 865.

45. The Hospital will have access to TH-NE's internal Value Analysis Committee and its group purchasing agreements providing advantageous pricing for products and supplies. Ex. A, p. 53, 85.

46. The most recent credit ratings for THC are as follows:
    - Fitch (December 2015): AA/Negative Outlook;
    - S&P (December 2015): AA-/Stable Outlook; and
    - Moody's (December 2015): Aa3/Stable Outlook.

    Ex. E, p. 871.

47. THC and TH-NE have agreed to ensure the expenditure of $100 million for capital expenditures at the Hospital and its current subsidiaries over the next five years following the closing date. If specific performance metrics are met in the 3rd and 4th year following the close of the transaction, an additional $10 million of committed capital in both the 4th and 5th fiscal year will be available. Ex. A, p. 21; Ex. E, p. 866.

48. The $100 million capital commitment, and additional $20 million if certain metrics are met, will be part of the $275 million capital commitment THC made to the recently formed TH-NE. THC is responsible for the $275 million capital commitment to TH-NE with TH-NE being responsible to ensure $120 million of the capital is allocated to the Hospital and its current subsidiaries. Ex. E, p. 866; Ex. G, p. 1018.

49. The funding sources of THC's $100M capital commitment will be:
    - Available cash and investments generated by the hospital;
    - Financing obtained through the THC system debt program; and
    - Capital contributions from THC, to the extent necessary.

    Ex. A, p. 116; Ex. E, p. 866.

50. The Hospital's annually budgeted $12 million for routine capital purchases is included in the $100 million capital commitment from TH-NE. Ex. E, p. 869.

51. Operating revenue from one hospital could be used to help fund capital improvements at another hospital within TH-NE, if a hospital is unable to raise the needed capital through its own operations. Testimony of Mr. Bittner, Ex. N, pp. 59-60.

52. The commitment of $100 million for the Hospital and its subsidiaries will not be reduced if future acquisitions were to take place. Ex. G, p. 1017.

53. The table below provides a preliminary capital investment plan for the Hospital. Approximately $40 million is for routine capital needs while the remaining $60 million is for strategic investments.

TABLE 7
PRELIMINARY CAPITAL INVESTMENT PLAN FOR THE HOSPITAL (IN THOUSANDS)

Description	Five Year Total
Hospital facility upgrades	$ 22,000
Replacement of clinical equipment	$18,000
Information Technology & Electronic Health Records	$12,000
Urgent Care / Ambulatory Care	$10,000
Ambulatory pavilion on campus	$25,000
Conversion to private patient rooms	$8,000
Clinically integrated network development	$5,000
Total estimated capital expenditures	**$100,000**

Ex. A, p.82.

54. The Hospital will have access to THC's intercompany loan program, if necessary, to develop a health information technology exchange (HITE) and electronic health records system. Ex. A, p. 31.

55. The Hospital will be subject to an annual intercompany system fee by TH-NE one year from the close of the transaction to help cover shared system office services. The shared resources include the departments of revenue, treasury, human resources, supply chain management and information technology. This will reduce the need for members of the TH-NE to use outsourced accounting, legal and consulting firms. Ex. E, p. 873-874; Ex. G, p. 1016-1017.

56. The shared system office services and resources-- and concomitant fee-- may increase to include additional resources and services in the future. Testimony of Mr. Bittner, Ex. N, pp. 49-50.

57. THC charges TH-NE 0.8% of operating expenses for providing the shared system office services. TH-NE will allocate the charge among its member hospitals and other subsidiaries. The fee will be determined based on the members 'comparative use of the system resources. Ex. G, p. 1016; Ex. L, pp. 1032-1033.

58. Based on savings observed at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue ($3.1M) is anticipated as a result of this proposal. Ex. A, p. 432.

59. The Hospital projects no incremental revenue for the first three fiscal years (FY 2016-2018) following the change in ownership, however operating gains of $1.5M, $3.1M and $3.2M, respectively, will be achieved from reductions in the cost of supplies and drugs and other operating expenses. Overall and with CON approval, the Hospital projects positive increasing gains from operations over the same time period.

TABLE 8
SAINT MARY'S HOSPITAL PROJECTED INCREMENTAL REVENUES AND EXPENSES (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	$0	$0	$0	$0
Total Operating Expenses	$0	($1,538)	($3,133)	($3,241)
Gain/Loss from Operations	**$0**	**$1,538**	**$3,133**	**$3,241**

TABLE 9
SAINT MARY'S HOSPITAL PROJECTED REVENUES AND EXPENSES WITH CON (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$301,416	$310,435	$319,530	$328,683
Total Operating Expenses	$297,061	$303,963	$311,078	$319,960
Gain/Loss from Operations	**$4,355**	**$6,472**	**$8,453**	**$8,723**

Ex. A, pp. 432-434; Testimony of Mr. Wable, Ex. N, p. 38.

60. The projected operational cost savings are summarized by expense category in the table below:

TABLE 10
SAINT MARY'S HOSPITAL PROJECTED OPERATING EXPENSE SAVINGS WITH CON (in thousands)

Expense Category	FY 2016	FY 2017	FY 2018	FY 2019
Supplies and Drugs	$0	($720)	($1,512)	($1,588)
Other Operating Expenses	0	($817)	($1,621)	($1,654)
Total Reductions	**$0**	**($1,538)**	**($3,133)**	**($3,241)**

Ex. A, p. 434;

61. THC's acquisitions of health systems and hospitals have yielded improved financial performances, cost savings and new capital investments:
    - Chelsea Community Hospital, Michigan - nearly a 40% increase in revenue between FY 2011 and FY 2016; approximately $67 million capital investment to construct a tower, including conversion to private acute beds; operating margin improved from 0.6% pre-merger to 4.4% in FY 2016;
    - Mercy Health, Hackley Campus, Michigan - annual aggregate savings of $1 million from enhanced revenue management and reduced supply and vendor costs; awarded 2016 America's Best Hospitals by Healthgrades; operating margin of 10% in FY 2015 compared to 1.0% in FY 2009, the first year after merging with THC;
    - St. Alphonsus Regional Medical Center, Idaho - $225 million in investments planned for campus relocation that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction; increase in Operating Cash Flow Margin to 16.3%, up from 6.4% in FY 2011; operating margin currently at 9.8%;
    - Loyola University Health System, Illinois - improved its first-year operational performance by $44.5 million across support functions, including insurance/risk

management, organizational integrity, supply chain, treasury, information services and revenue cycle; operating margin and operating cash flow margins have improved from -1.4% and 4.0% respectively to 1.2% and 6.5% in FY 2015;

- Catholic Health East, with facilities across 9 states - $285 million of synergies since the system level mergers occurred in May 2013, with more than $25 million in additional synergies planned through June 2016; operating expenses of $13.9 billion in FY 2015 with synergies savings of 1.8% of operating expenses; and
- St. Joseph Health, Inc., New York - $4 million in savings since merging with THC on July 2015 representing a synergies savings of 0.6% of operating expenses.
- St. Francis Hospital and Medical Center, Connecticut - has been a part of THC for over a quarter, but anticipated annualized savings of 7.6 million is expected to be realized representing 1% of operating expenses; a fixed pay interest rate swap was transferred to THC resulting in $44 million reduction in liability strengthening the balance sheet by increasing its unrestricted net assets.

Ex. E, pp. 872-873; Ex. G, p. 1018-1021.

62. There have been no changes in the price structure resulting from recent acquisitions other than St. Alphonsus Medical Center. Prices increased by approximately 12% as prior to the acquisition, prices had not increased for four years. Ex. G, p. 1021.

63. The Membership Transfer Agreement provides that within one year following closing, THC will develop a plan to address the Hospital's third party debt and to fully fund its pension plan obligations. Ex. A, pp. 114-115.

64. The Hospital's pension plan is underfunded by $75.9 million and its funding status was at 48% as of 9/30/2015. Currently, there are no plans to restructure the debt. A review to determine if an intercompany loan will be used to pay off or refinance the outstanding debt will be conducted post-closing. Ex. E, pp. 870-871; Ex. L, p. 1025; Testimony of Mr. Bittner, Ex. N, pp. 55-56.

65. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

66. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

67. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

68. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

69. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5))

70. The Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))

71. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

72. The Applicants provided historical utilization of Saint Mary's Health System services in the service area that supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

73. The Applicants have satisfactorily demonstrated that this proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

74. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))

75. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. (Conn. Gen. Stat. § 19a-639(a)(11))

76. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12))

DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

Saint Mary's Health System, Inc. ("SMHS") is a not-for-profit integrated Catholic health care delivery system serving the greater Waterbury area. *FF1.* SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliates. *FF2.* The Hospital, a 347-bed acute care general hospital, has served the greater Waterbury area since 1907, and is licensed as a Level II Trauma Center. It provides a full range of inpatient, outpatient and ancillary services to the 16 towns encompassing its primary service area. *FF3-4.*

In response to changes in health care delivery as well as federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to that of an accountable care organization focusing on population health management. SMHS determined it could best effectuate this and other goals of its strategic plan through a partnership. *FF5.* Additionally, the need for capital improvements to an aging infrastructure, the mandate to provide health services as reflected in the Community Health Needs Assessment, the requirement to meet the medicals records standard as a result of the Patient Protection and Affordable Care Act ("PPACA") and SMHS's debt obligations have made the need to partner with another health care provider essential in order to maintain the quality of care currently provided. *FF6.* SMHS, through its SMHS Board Taskforce ("Taskforce"), has been searching for a partner that would meet its philosophical principles and the resources to improve SMHS's financial strength. *FF7.* The Taskforce found Trinity Health Corporation ("THC") and the New England Regional Health Ministry ("TH-NE") to have a strategic plan similar to its own while sharing a common vision, philosophy, mission and compatible religious directives. *FF7-8.*

THC is a national Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs in 21 states. It is the sole shareholder of TH-NE. *FF11.* TH-NE is the parent company of health care facilities located in Connecticut, including Saint Francis Hospital in Hartford. *FF12.*

SMHS's Board of Directors approved a strategic alliance with TH-NE based on the findings and recommendation of the Taskforce. A membership agreement was signed on September 19, 2015. *FF9.* As a result of this agreement, the Applicants are requesting approval to transfer ownership of SMHS and its subsidiaries to TH-NE in order to become part of THC. *FF10.*

Following the completion of the transfer of ownership, it is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. *FF17.* TH-NE will be the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. *FF18.* The Applicants propose adding two members from the Hospital's community to the TH-NE Board of Directors who will be appointed by THC for three years. *FF19.* The governing board of the Hospital will remain unchanged other than the addition of the CEO of TH-NE. *FF19.* To ensure

quality concerns and the local health needs of the community are identified, local boards will have the ability to pass on relevant information to the regional governing boards through a representative. *FF20.*

TH-NE's organizational structure aims to create a system that meets the PPACA's objectives of improving population health and enhancing patient care experience while controlling costs. *FF13.* The Hospital will be able to leverage TH-NE's data and evidence-based national infrastructure to align and support clinicians in a Unified Clinician Organization ("UCO"). This will enable medical practitioners to work collaboratively throughout the THC-system to advance patient safety, best practices, quality and patient satisfaction. Hospitals participating in the TH-NE's UCO initiative have seen a decrease in sepsis mortality and pressure ulcer rates as well as an increase in patient satisfaction measures. *FF15.* Additionally, to address the increasing cost of hospital readmission, THC has developed a post-acute affiliated network resulting in a more accurate and efficient transition of patients from the hospital to the next level of care. *FF16.* The Hospital will be able to take advantage of THC's UCO and the associated best practices.

The Health Resources and Services Administration has designated Central Waterbury as a as a medically underserved area and medically underserved population. By affiliating with THC, the Hospital will gain the resources to strengthen health care in the region. *FF 25-26.* The Hospital's 2013 Community Health Needs Assessment ("CHNA") has identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement. *FF28.* The Hospital has also adopted the Connecticut Hospital Association's initiative to reduce instances of chronic conditions, specifically choosing to focus on asthma prevention. *FF29.* TH-NE has committed to integrating the health priorities identified by SMHS and the Hospital into its Community Health and Well-Being Strategy. *FF27.* The proposal will also benefit the local community by increasing access to resources of a large system, and its ability to develop more preventive and primary care services.

Following implementation of the proposal, an efficiency analysis will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize processes. However, neither the Hospital's clinical services nor its locations are expected to change as a result of this proposal. *FF21.* Additionally, the Hospital's Board would be required to approve a termination or a reduction of a service if it were to occur within three years following implementation. *FF22.* There are no proposed changes in services for the indigent or the Medicaid patients served by the Hospital. Furthermore, The Applicants do not anticipate any significant changes in the overall payer mix. *FF38-39.*

SMHS's charitable policies are consistent with both THC and TH-NE with no planned changes, thus ensuring that access to services for the Medicaid and indigent population continue. *FF41.* All charitable gifts to the Hospital will remain a part of the Hospital's Foundation and will continue to operate separately from the Hospital. All donations will continue to comply with existing donor restrictions. *FF42-43.* As a result, the integration of the Hospital with THC and TH-NE will allow the Hospital to maintain its commitment to the poor, the uninsured and underinsured as well as the Medicaid population.

There are no capital cost associated with the Transfer Agreement between the Applicants. *FF23.* Additionally, the proposal will enable the Hospital to make needed capital upgrades and investments. As a condition of THC's 2015 acquisition of Saint Francis *Care* and subsequent establishment of TH-NE, THC made a capital commitment of $275M to TH-NE. *FF48.* TH-NE is now proposing to commit at least $100M of that capital funding over the next five years to the Hospital. NE-RHM will contribute an additional $20M if the Hospital meets specific metrics in the 3rd and 4th year following the close of the transaction. *FF47.* Funding for the committed capital will be derived from cash and investments generated by the Hospital, financing obtained through the THC-system debt program and, if necessary, capital contributions from THC. *FF49.* The committed capital of $100M is a minimum that will not erode if further mergers were to occur. *FF52.*

The preliminary capital investment plan includes $40M in Hospital facility upgrades including the replacement of clinical equipment that has been delayed due to budgetary constraints. The remaining $60M is intended for the development of an electronic health records system, improving ambulatory care, converting to private patient rooms and developing a clinical network. *FF53.* In addition, the Hospital will be able to secure better long-term capital at favorable interest rates utilizing THC's strong credit ratings as well as develop a plan to adequately fund its pension obligations. *FF25, FF63.*

Cost savings will be achieved at the Hospital as a result of synergies expected to be realized as a result of becoming part of a larger system. Some synergies will be realized through a system of shared office services by THC members. The departments of revenue, treasury, human resources, supply chain management and information technology will be centralized. *FF55.* For use of these services, THC will impose a charge of 0.8% of NE-RHM's operating expenses, to be distributed among NE-RHM's member hospitals. Centralizing these departments will, however, likely result in net savings for TH-NE's members. *FF57.*

Based on observations at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue is anticipated as a result of this proposal. *FF58.* No incremental revenue for FY 2016 to 2018 is projected; however, operating gains of $1.5M, $3.1M, and $3.2M, respectively, are projected, in part, from reductions in the cost of supplies and drugs. In addition, the Hospital projects positive and increasing gains from operations following the transfer. *FF59.*

As a result of the potential for improved financial performance and new capital investments, the Applicants have demonstrated that the proposal is financially feasible and that the financial strength of the health care system will be improved by providing the Hospital with financial stability through improved access to capital and debt financing to preserve and enhance existing services.

The proposal will allow the Hospital to access TH-NE's system of best clinical practices, centralized office functions, and cost savings measures. Such benefits will enable the Hospital to invest in beneficial capital upgrades while still meeting its debt obligations and maintaining positive financial margins.

As a result of these combined factors, the Applicants have satisfactorily demonstrated that there is a clear public need for the proposal and that quality of care will improve through integration with a national system providing a variety of clinical and financial benefits. Thus, the Applicant has demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the transfer of ownership of SMHS and its controlled affiliates to Trinity Health – New England, Inc., a subsidiary of Trinity Health Corporation is hereby **Approved** under Conn. Gen. Stat. §19a-639 subject to the enumerated conditions (the "Conditions") set forth below

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether THC remains the parent company and sole shareholder of the Trinity Health–New England, Inc. ("TH-NE") OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, and the right to impose and collect a civil penalty under Conn. Gen. Stat. § l9a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the applicable website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§19a-613(b), 19a-639(a)(8) & (11); FF 21-22.*

2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall identify and provide the Certificates of Incorporation for the THC or TH-NE -affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. This entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-613(b), 19a-639(a)(8) & (11); FF 17-18*

3. TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:
    a. the Transfer Agreement, including any and all schedules and exhibits; and
    b. Bylaws or similar governance documents for the Hospital.

    TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If TH-NE redacts materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §19a-613(b); FF 9- 10, 19-20, 34.*

4. Following the completion of the Hospital's 2016 Community Health Needs Assessment (CHNA), TH-NE shall participate with the Hospital, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion. TH-NE and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. In the event that the Hospital has already substantially completed its 2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six months of the Closing Date. TH-NE shall publish the Community Health Needs Assessment and the Implementation Strategy on the website of the Hospital. Until such time as the CHNA and Implementation Strategy are submitted to OHCA, TH-NE shall continue to support and implement the Hospital's current CHNA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3) & (7); FF 27-30*

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

6. Until such time as the Services Plan is submitted, TH-NE shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date.

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[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF -21-22*

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

8. For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:

    a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

        1. the major cost savings achieved for each expense category for the semi-annual period; and

        2. the effect of these cost savings on the clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/350 (statement of operations) or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5);* FF *47-49, 53*

9. For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for the Hospital and TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio

6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Net Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5); FF 59-60*

10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

11. For three (3) years following the Closing Date, TH-NE shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of the Hospital within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the Hospital simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

13. TH-NE shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, TH-NE shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, TH-NE shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, TH-NE shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, TH-NE shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 29.*

14. For three (3) years following the Closing Date, Trinity shall allow for one (1) community representative to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting member under the Hospital's Board of Director Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of one unbiased persons who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 19-20*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

7-25-16
Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by D. SCOTT WORSWICK, EVP, GROWTH, STRATEGY + INNOVATION
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

July 22, 2016
Date

Duly Authorized Agent for
Trinity Health-New England

Signed by Christopher Dadlez, President + CEO
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

7/22/16
Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by Chad W. Wable, FACHE, President and Chief Executive Officer
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Saint Mary's Health System, Inc. and Trinity Health, Inc.

DN: 15-32045-CON

Hearing Date: May 9, 2016

Time: 3:00 PM

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Exhibit #	Description
1	Letter from Joan Hartley & Jeffery Berger
2	
3	
4	
5	

Intervenor Exhibit #	Description
1	
2	
3	
4	
5	
6	
7	

Informal Exhibit #	Description
1	
2	
3	
4	
5	
6	
7	

Applicant Late File #	Description	Due Date	Rec'd
1	Support Schedule showing how cash flow amounts were determined		
2			
3			
4			
5			
6			

Intervenor Late File #	Description	Due Date	Rec'd
1			
2			
3			
4			
5			
6			

Notes:

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Christopher DADDEZ	860-714-1915		Trinity Health-NE
James Richard O'Connell	719-332-0340		Trinity Health
David Bittner	860-714-1950		Trinity Health-NE
James Hawnis	860-714-4396		Trinity Health-NE
Adam Silverman	860-714-1966		↓

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Marcos M. McKinney	860 805-5971		Trinity Health NE
Jennifer J. Schneider	860 714-5360		Saint Francis Hospital - medical Gr
Thomas S. Marcian	860-331-2660		Hinckley Allen/Trinity Health NE
Robert J. Anthony	860-509-6517		Brown Rudnick/Saint Mary's
Michael G. Tabor	401-457-5239		Hinckley Allen/Trinity Health NE
Ralph Becker	203-709-5871		Saint Mary's
Chris Hayes	203-709-6294		Saint Mary's
Steven Schneider	203 709 3044		Saint Marys
Claudia Capone	860.276.7875		Trinity Health - NE
Robert J Mazurka	203-888-9181		St. Marys

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Chad Wolfe	203 709-3368		Saint Mary's Hospital
Liz Rotavera	860 714-5153		Saint Francis
Chris Hartley	860 714-5573		Saint Francis
PAT GERNER	860 794-1907		SAINT MARY'S
Joe Connolly	203 709 6369		SAINT Mary's

Applicant

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization

Public Official

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Ronald Pugliese	203 723.4411	203 729-4512	Naugatuck Economic Development
William Quinn, Waterbury Dir. of Health	203-574-6780	203-597-3481	City of Waterbury, Dept. of Health
Lynn Ward	203-757-0701	203-756-3507	Waterbury Regional Chamber
Neil O'leary			Mayor of Wtby

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

PRINT NAME	Representing Organization
Nicholas J Coscia	Open Health Patient
Amit Mody MD	TMNE
MaryAnn Manley	St. Frances
Kevin Sullivan	Johnson Memorial Hospital
William [illegible]	[illegible]

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Stuart E. Rosenberg	Johnson Memorial Hospital
Joseph Carlson II	Public
Paul Kelly	Public
Kevin Reynolds	RSG
Hillary Glass	RSG
Phil Tartsinis	JMMC
Fiona Phelan	Saint Francis
Brenda Saxe	RSG
Harry Rosenthal	Y-NHHTS
S. Dolorosharn CSJ	SMH

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Patty Chant	Waterbury Hospital
Dick Pugh	ST Marys Hospital
CHRISTINA MASON	REPUBLICAN-AMERICAN NEWSPAPER
Nancy Rousseau	Trinity Health New England
CHRIS MILLER	SHARON HOSPITAL
Peter Cordeau	Sharon Hospital
Christian Bergeron	Sharon Hospital
Jennifer Clement	Saint Marys Hospital

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

May 9, 2016
3:00 p.m.

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

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Nicholas J Cosca	OpenHealth Patient
Amit Mody MD	THNG
MaryAnn Manley	St. Frances
Kevin Sullivan	Johnson Memorial Hospital
William [illegible]	[illegible]

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
STUART E. ROSENBERG	JOHNSON MEMORIAL HOSPITAL
Joseph Carlson	Public
PAUL KELLY	Public
Kevin Reynolds	RSG
Hillary Glass	RSG
Phil Tartsinis	JMMC
Fiona Phelan	Saint Francis
BRENDA SISCO	RSG
Nancy Rosenthal	YNHHS
S. Doloreshann CSJ	SMH

Saint Mary's Health System, Inc. and Trinity Health, Inc.

PRINT NAME	Representing Organization
Patty Chant	Waterbury Hospital
Dick Pugh	ST Marys Hospital
CHRISTINA MASON	REPUBLICAN-AMERICAN NEWSPAPER
Nancy Rousseau	Trinity Health New England
CHRIS MILLER	SHARON HOSPITAL
Peter Cordeau	Sharon Hospital
Christian Bergeron	Sharon Hospital
Jennifer Clement	Saint Mary's Hospital

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

May 9, 2016

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Martone:

I am pleased to offer this testimony in support of the Certificate of Need application submitted by Trinity Health New England, Inc.'s Acquisition of Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.

I am supportive of this merger, in part, because I believe that Saint Mary's will be able to retain their local commitment, including their Catholic identity and mission, while being part of a more financially secure regional system. The $100 million commitment over five years will allow Saint Mary's to improve the delivery of quality care and help fulfill its community based mission. Patients will have greater access to medical expertise and shared resources.

Changes are occurring in our health care delivery system. I view the change contemplated in this transaction as a very positive step for Saint Mary's and the Greater Waterbury community. I thank you for your consideration of this proposal.

Very Truly Yours,

Joan Hartley
State Senator, 15th District

Jeffrey J. Berger
State Representative, 73rd District

Printed on recycled paper.

Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, August 19, 2016 9:20 AM
To: Greer, Leslie
Cc: Attorney Bob Anthony; Lubin-Szafranski, Janeanne; Joe Connolly (JConnolly@Stmh.org); Victoria Cipriano
Subject: Responses to 15-32045-CON Conditions
Attachments: Responses to 15-32045-CON Conditions - CAC - 8 18 2016.pdf

Hello Leslie,

Attached are Saint Mary's responses to conditions for CON Docket #: 15-32045-CON. A paper copy is being mailed as well. Please feel free to contact me with any questions you may have.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

Trinity Health
New England

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1000 Asylum Ave.
Hartford, CT 06106
860.714.6465
Fax: 860.714.8823

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

August 19, 2016

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue
MS#13HCA
P.O Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Greer:

In accordance with Items 1, 2, 3, 6 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

1. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the decision Date and publish this same information on the applicable website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.**

   In accordance with Condition 1 of the Order, Trinity Health – New England, Inc. is submitting schedules to OCHA setting forth Saint Mary's Hospitals inpatient bed allocation along with the location & hours of operation for all outpatient services by department (**See Attachment 1**). Currently, locations and hours of operation can be viewed on the Saint Mary's Hospital's website (www.stmh.org).

2. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE- affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. The entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral.**

   In accordance with Condition 2 of the Order, Trinity Health – New England, Inc. is submitting the Certificate of Incorporation for the TH-NE affiliated entities that shall directly own, operate and hold the hospital's license post-closing along with the document of existence under the laws of CT (**See Attachments 2**).

3. **TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:**
   a. **The Transfer Agreement, including any and all schedules and exhibits; and**
   b. **Bylaws or similar governance documents for the Hospital.**

   TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. 1-210. If TH-NE redacts materials in accordance with the previous sentence, the Applications shall provide a list to

OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral.

In accordance with Condition 3.a. of the Order, Trinity Health – New England, Inc. ("TH-NE") is submitting a copy of the Transfer Agreement, including any and all schedules and exhibits. Pursuant to Condition 3, TH-NE has redacted Schedule 6.15(a) from the copy of the Transfer Agreement submitted: Schedule 6.15(a) identifies correspondence from various state and federal agencies, contractors, and payors discussing matters relating to compliance with state and federal laws and reimbursement rules. The redacted information is exempt from disclosure because it is commercial or financial information given in confidence by the parties to each other even though such disclosure is not required by statute (see Conn. Gen. Stat. § 1-210 (5) (B)). Moreover, public disclosure of this information would unduly harm the parties and may create unwarranted unease among patients, potential patients, physicians, and other members of the community (**See Attachment 3**).

6. Until such time as the Services Plan is submitted, TH-NE shall provide OCHA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for patient population.

In accordance with Condition 6 of the Order, Trinity Health – New England, Inc. ("TH-NE") is notifying OCHA that there are no plans to reallocate inpatient beds or relocate any outpatient services for Saint Mary's Hospital at this time.

10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 1

IP Bed Allocation	
Department	Staffed Beds
Medical Acute (SH5)	21
Behavioral Health Services (OB1)	12
Telemetry	20
Orthopedics/Neuro (OB-4)	30
Medical Oncology (X-3)	26
General Surgery (OB-7)	23
Critical Care Unit	16
Cardiovascular Unit	8
Lobor/Delivery	23
Total Staffed Beds	179

OP Services by Department			
Department	**Location**	**Hours of Operation**	**Contact**
Behavioral Health Care Services	100 Visitation Plaza Waterbury, CT 06706	M, W & Th: 8A-8P T & F: 8A-4:30P	203-709-6201
Child Development Center	100 Visitation Plaza Waterbury, CT 06706	M-F: 6:30A - 5:45P	203-709-6385
Family Health Center	95 Scovill Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-3800
Naugatuck Valley Surgical Center	160 Robbins Street Waterbury, CT 06708	M-F: 6A -5P	203-755-6663
Cardiovascular Diagnostic Center	1320 West Main Street Waterbury, CT 06708	M-F: 6:30A - 3P	203-709-4506
Saint Mary's Blood Draw - East Main Street	1981 East Main Street Waterbury, CT 06705	M-Th: 7A-4:30P F: 7A-3P Sat: 7A -10:45A Hours for X-Ray M-Th: 8A-5P F: 8A-12P	203-709-6052
Saint Mary's Blood Draw- West Main Street	1312 West Main Street Waterbury, CT	M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P Hours for X-Ray M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P	203-709-4575
Saint Mary's Blood Draw- Scovill Street	133 Scovill Street Waterbury, CT 06706	M-F: 8:30A - 5P	203-709-3660
Saint Mary's Blood Draw-Southbury	303 Union Square, Southbury CT	M-F: 7A-4P Sat: 7A-11A	203-267-5611
Saint Mary's Blood Draw- Watertown	70 Hemingway Park Road Watertown, CT	M-F: 7:30A-4P	203-709-5931
Saint Mary's Urgent Care Center - Naugatuck	799 New Haven Road, Naugatuck CT	M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P	203-723-5636
Saint Mary's Urgent Care Center - Wolcott	503 Wolcott Road, Wolcott CT	M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P	203-879-7900

One Stop Testing (SMH)	56 Franklin Street Waterbury, CT 06706	M-F: 6A - 6P	203-709-6103
Saint Mary's Hospital Oncology Center	1075 Chase Parkway Waterbury, CT 06708	M-F: 7A-5P	203-591-3077
SMH Physical & Occupational Therapy - Waterbury	1981 East Main Street Waterbury, CT 06705	OT Hours M& W: 8:30A-7P T&Th: 7:30A-3P F: 8:30A - 2:30P PT Hours M-Th: 7A-7P F: 7A-5:30P	203-709-6232
SMH Physical Therapy & Low Vision Center - Naugatuck	799 New Haven Road, Naugatuck CT	M, T & F: 8A - 4:30P W & Th: 7A - 5:30P	203-720-1750
Saint Mary's Hospital Sleep Disorders Center - Wolcott	503 Wolcott Road, Wolcott CT	Friday: 9A - 12P Sleep Lab 9A-6P 7:30P - 6A	203-709-6243
Wound Center	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-3000
Saint Mary's OP Therapy	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4:30P	203-709-6216
OP Cardiac Rehab	56 Franklin Street Waterbury, CT 06706	M-F: 7A - 3:30P	203-709-6202
Saint Mary's OP Imaging	56 Franklin Street Waterbury, CT 06706	M-F: 6:30A - 8P Sat & Sun: 7A - 3:30P	203-709-6021
Same Day Surgery	56 Franklin Street Waterbury, CT 06706	M-F: 6A - 8P	203-709-6069
Nutrition Center	56 Franklin Street Waterbury, CT 06706	M: 11A - 5:30P T-F: 8:30A - 3:30P	203-709-3247
Saint Mary's Occupational Health & Diagnostic Center	1312 West Main Street Waterbury, CT	M-F: 8A - 4:30 P	203-709-3740
Saint Mary's Hospital Urgent Care - West Main Street	1312 West Main Street Waterbury, CT	M-F: 8A - 8P Sat: 9A - 5P Sun: 9A - 2P	203-709-4575
OP Pulmonolgy Clinic	56 Franklin Street Waterbury, CT 06706	M-F: 8A - 4P	203-709-6244
OP Cardiac Testing	56 Franklin Street Waterbury, CT 06706	M-F: 7A - 3:30P	203-709-6361

ATTACHMENT 2

AMENDED 11/17/2015

Amended and Restated Certificate of Incorporation of

Trinity Health – New England, Inc.

A Connecticut Nonstock Corporation

1. This Amended and Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

2. The text of the Amended and Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Trinity Health – New England, Inc. which was incorporated on July 31, 1997.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation as amended from time to time.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Trinity Health – New England, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Trinity Health Corporation, an Indiana nonprofit corporation, which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III
Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which,

in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Member and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

B. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

C. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

D. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

E. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

F. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations

exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

G. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

H. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) (or, if the Corporation is so classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV

Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Trinity Health Corporation, an Indiana nonprofit corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is c/o CT Corporation System, One Corporate Center, Hartford, CT 06103. The resident agent of the Corporation is CT Corporation System, One Corporate Center, Hartford, CT 06103. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Trinity Health Corporation, an Indiana nonprofit corporation is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member shall have exercised its reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member:

a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(b) Appoint and remove Directors of the Corporation, with or without cause, of if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(c) Ratify the appointment and removal of the Chair of the Board of Directors of the Corporation;

(d) Appoint and remove the President of the Corporation;

(e) Approve the strategic plan of the Corporation to the extent required pursuant to the System Authority Matrix, which shall be consistent with the strategic plan of Trinity Health;

(f) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health;

(g) Approve the operating and capital budgets of the Corporation;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries);

(j) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation;

(k) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation;

(l) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may be subject to approval by Catholic Health Ministries);

(m) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code;

(n) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by Trinity Health pursuant to this provision;

(o) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than to Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business; and

(p) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit corporations, as the case may be) by the state laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

ARTICLE VIII

Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a director, officer, employee, committee member, or agent of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for

such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Amended and Restated Certificate of Incorporation

This Amended and Restated Certificate of Incorporation is effective as of October 1, 2015.

Office of the Secretary of the State of Connecticut

I, the Connecticut Secretary of the State, and keeper of the seal thereof, DO HEREBY CERTIFY, that the certificate of incorporation of

TRINITY HEALTH - NEW ENGLAND, INC.

a domestic NONSTOCK corporation, was filed in this office on July 31, 1997, a certificate of dissolution has not been filed, the corporation has filed all annual reports, and so far as indicated by the records of this office such corporation is in existence.

Secretary of the State

Date Issued: August 10, 2016

Business ID: 0568101 Express Certificate Number: 2016249150001

Note: To verify this certificate, visit the web site http://www.concord.sots.ct.gov

ATTACHMENT 3

Execution Copy

TRANSFER AGREEMENT

by and among

SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

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TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE I
DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01**.

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01**.

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06**.

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06**.

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02**.

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

"Certification of AFTAP" has the meaning set forth in **Section 6.22(c)**.

"**Church Plan**" has the meaning set forth in **Section 6.22(e).**

"**Closing**" has the meaning set forth in **Section 5.01**.

"**Closing Date**" has the meaning set forth in **Section 5.01**.

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01**.

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a).**

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04**.

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth **in Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"NE-RHM" has the meaning set forth in the preamble.

"NE-RHM Controlled Subsidiary" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"NE-RHM Providers" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"Trinity Health Controlled Subsidiary" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

"Withdrawal Liability" has the meaning set forth in **Section 6.22(d)**.

ARTICLE II
TRANSFER

Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH. As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy. In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

ARTICLE III
GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

Section 3.01 Governance. As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

Section 3.02 NE-RHM Board of Directors. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

Section 3.03 Other Appointments. A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

Section 3.04 President and CEO of Saint Mary's. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

Section 3.05 Name and Branding. Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

Section 3.06 Catholic Identity. Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

Section 3.07 Operational Commitments. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

Section 3.08 Medical Staff. Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

Section 3.09 Community Benefit.

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

Section 3.11 Debt and Long-Term Liabilities.

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

ARTICLE IV
CAPITAL COMMITMENT

Section 4.01 Capital Commitment. During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

Section 4.02 Use of the Committed Capital. The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

Section 4.03 Obligation to Repay Loans. Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

Section 4.04 Additional Capital Needs. The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

ARTICLE V
CLOSING

Section 5.01 Closing. Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

Section 5.02 Closing Deliverables.

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE VI
REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

Section 6.01 Organization and Corporate Authority.

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

Section 6.02 Tax-Exempt Status. Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 6.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

Section 6.04 No Conflicts; Consents. The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

Section 6.05 Saint Mary's Subsidiaries. The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

Section 6.06 Financial Statements. Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

Section 6.07 Undisclosed Liabilities. Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

Section 6.08 Absence of Certain Changes, Events and Conditions. Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

Section 6.09 Material Contracts.

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c),** and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

Section 6.10 Title to Saint Mary's Assets.

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

Section 6.11 Condition and Sufficiency of the Saint Mary's Assets. Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

Section 6.12 Real Property.

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

Section 6.13 Intangible Personal Property; Software.

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

Section 6.14 Legal Proceedings; Governmental Orders.

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

Section 6.15 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

Section 6.16 Medicare Participation/Accreditation

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

Section 6.17 Compliance Programs

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 6.18 Corporate Integrity Agreements. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 6.19 HIPAA. To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

Section 6.20 Affiliate Transactions. Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.21 Environmental Matters.

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

Section 6.22 Employee Benefit Matters.

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

Section 6.23 Employment Matters.

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

Section 6.24 Taxes.

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

Section 6.25 Insurance. Schedule 6.25 of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

Section 6.26 Medical Staff. SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

Section 6.27 Brokers. Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

Section 6.28 Due Diligence. Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

Section 6.29 Full Disclosure. No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 6.30 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

Section 7.02 Tax-Exempt Status. Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

Section 7.03 Authorization and Enforceability of this Agreement. The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

Section 7.04 No Conflicts; Consents. The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.05 Brokers. Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

Section 7.06 Legal Proceedings. There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

Section 7.07 Financial Statements.

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

Section 7.08 Compliance with Laws; Permits.

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

Section 7.09 Medicare Participation/Accreditation

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

Section 7.10 Compliance Programs

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

Section 7.11 Corporate Integrity Agreements. Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

Section 7.12 HIPAA. To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12**.

Section 7.13 Financial Capacity. NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

Section 7.14 Due Diligence. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

Section 7.15 Full Disclosure. No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

Section 7.16 No Other Representations and Warranties. Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

ARTICLE VIII
COVENANTS

Section 8.01 Conduct of Operations Prior to the Effective Date.

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

Section 8.02 Regional Strategy/Structure and Integration Plan. As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

Section 8.03 Access to Information.

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

Section 8.04 Efforts to Consummate. Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

Section 8.05 Updated Financial Statements. Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

Section 8.06 Employment Matters.

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

Section 8.07 Insurance.

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

Section 8.08 Title and Survey Matters.

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

Section 8.09 Transfer Taxes. All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

Section 8.10 Public Announcements. Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

Section 8.11 Confidentiality.

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

Section 8.12 Updated Disclosure Schedules. Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

Section 8.13 Further Assurances. Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

Section 8.14 No Shop. The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

ARTICLE IX
CONDITIONS TO CLOSING

Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health. The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

Section 9.02 Conditions Precedent to Obligations of Saint Mary's. The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy Law or any other similar Law or statute of the United States or any state, nor shall any such petition have been filed against NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

ARTICLE X
TERMINATION

Section 10.01 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

Section 10.02 Effect of Termination. In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X**, **Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Survival. None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

Section 11.02 Expenses. Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

Section 11.03 Notices. All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

If to Saint Mary's
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

With a copy to:
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

Section 11.04 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

Section 11.05 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

Section 11.06 Severability. If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

Section 11.07 Entire Agreement. This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

Section 11.08 Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

Section 11.09 No Third Party Beneficiaries. This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 11.10 Amendment and Modification; Waiver. This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

Section 11.11 Governing Law; Submission to Jurisdiction. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

Section 11.12 Specific Performance. The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

Section 11.13 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

TRINITY HEALTH CORPORATION

By: _____

Name: James R. O'Connell

Title: Executive Vice President

SAINT FRANCIS CARE, INC.

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

EXHIBITS AND DISCLOSURE SCHEDULES TO

MEMBERSHIP TRANSFER AGREEMENT

by and among

TRINITY HEALTH CORPORATION

and

SAINT MARY'S HEALTH SYSTEM, INC. and
SAINT MARY'S HOSPITAL, INC.

Dated as of September 18, 2015

EXHIBITS

Exhibit A .....Saint Mary's Exempt Subsidiaries

Exhibit B .....Saint Mary's Controlled Subsidiaries

Exhibit C .....Trinity Health System Authority Matrix

Exhibit D .....SMH Amended and Restated Certificate of Incorporation and Amended and Restated Bylaws

EXHIBIT A

SAINT MARY'S EXEMPT SUBSIDIARIES

Saint Mary's Hospital, Inc.

Saint Mary's Hospital Foundation, Inc.

EXHIBIT B

SAINT MARY'S CONTROLLED SUBSIDIARIES

Saint Mary's Hospital, Inc.

Saint Mary's Physician Partners, LLC

Saint Mary's Indemnity Company, LLC

Franklin Medical Group, P.C.

Diagnostic Imaging of Southbury, LLC

Naugatuck Valley MRI, LLC

EXHIBIT C

TRINITY HEALTH SYSTEM AUTHORITY MATRIX

See attached

June 25, 2015

TRINITY HEALTH
System Authority Matrix

This Authority Matrix summarizes a number of important activities that might be taken by an entity within the Trinity Health System and the corresponding actions or approvals that must be taken before proceeding with such activity. Many of these actions are delegations from the Board of Trinity Health to management, to Committees of the Board of Directors of Trinity Health and to governance of entities affiliated with Trinity Health. Trinity Health has adopted the following Operating Principles which apply to these delegations:

Unity: We act as a unified system, recognizing the interdependency of all its parts in fulfillment of its mission and vision while promoting the strength of our ministries serving our unique communities.

Excellence: We seek to continually innovate and improve our performance excellence and to add value by leveraging our skill and scale.

Simplicity and Clarity: Local, regional and system office leadership work in partnership to make decisions in a timely and collaborative manner that takes into account the variety of interests being affected.

Accountability: We are flexible in shaping roles, responsibilities and accountabilities at all leadership levels of the organization.

The Trinity Health Board retains control over its statutory obligations in carrying out the purposes of the corporation as the parent of a large Catholic health system. The Board is responsible for key strategic decisions and issues that will significantly impact the Trinity Health System. Delegations are established taking into account the balance between making efficient decisions close to the business activity and the need for the board and management to oversee areas of significant impact on the system as a whole in terms of Catholic Identity, strategic direction, risk and value.

The Board has adopted a process of Mission Discernment, which is intended to ensure that in the course of making major decisions, the Mission and Core Values are used as a measure to evaluate the effect of the proposed action.

This Authority Matrix is not intended to be an exclusive listing of the various actions reserved to Trinity Health or its affiliated entities. Trinity Health may clarify these delegations through policies. State law may confer additional rights or require additional actions. Those variations will be set forth in the governing documents of the entity and prevail over any conflicting authorities described in this System Authority Matrix. Different rights may also be set forth in the terms of joint venture organizing documents or other agreements. Decisions related to those joint venture entities should be made in accordance with the organizing documents; however, decisions which exceed financial thresholds or which may, in management's judgment, affect the reputation or identity of the Trinity Health System are required to be reviewed by Trinity Health management, regardless of the minority position held by the CHE Trinity affiliate in the joint venture.

Entities:

Catholic Health Ministries or CHM means the public juridic person that sponsors the Trinity Health system and exercises all canonical responsibilities related to its operations, subject to certain rights retained by sponsoring congregations or public juridic persons until such time as the stable patrimony (property) under the control of those sponsoring congregations or public juridic persons is alienated (transferred) to CHM.

Trinity Health means Trinity Health Corporation, an Indiana nonprofit corporation, which is the parent of the Trinity Health System.

Trinity Health System means Trinity Health, together with its subsidiaries and affiliates.

Ministry or Ministries means any or all RHMs, NHMs, and MHMs.

Mission Health Ministry or MHM means a first tier subsidiary of Trinity Health that maintains a governing body and which has oversight of non-institutional health operations and/or grant making. A list of MHMs is set forth on Exhibit A to this Matrix.

National Health Ministry or NHM means a first tier (direct) subsidiary that maintains a governing body that has day to day management oversight of a business line throughout the Trinity Health System. A list of NHMs is set forth on Exhibit A to this Matrix.

Regional Health Ministries or RHM means a first tier (direct) subsidiary, affiliate or operating division of Trinity Health that maintains a governing body that has day to day management oversight of a designated portion of the Trinity Health System within a geographical market. A list of RHMs is set forth Exhibit A to this Matrix.

Group 1 RHM means an RHM which had a minimum total operating revenue of $300 million in the previous fiscal year or an RHM that has been selected by management for inclusion in Group 1 RHMs based on operational objectives.

Group 2 RHM means an RHM which is not a Group 1 RHM.

Second Tier Subsidiaries means subsidiaries and affiliates of Ministries.

Actions:

Approve means to have ultimate authority over an action. Approval includes the authority to adopt, accept, modify, disapprove or send back for further consideration an action recommended or approved by another entity in the Trinity Health System. Some actions required approval at more than one level. Final approval authority is exercised by the highest level independently of any recommendation or participation actions. If more than one entity has Approval authority, the matter may be initiated and approved by the highest level of Approval authority when permitted by law.

Participate means a timely, meaningful, collaborative and consultative process among interested parties to inform the decision under consideration.

Ratify means to confirm and adopt the act of another even if it was not approved beforehand. It also means final decision making authority, but without the power to initiate or change a recommendation.

Recommend means to review and present a matter for approval by another entity in the Trinity Health System. Recommending authority does not limit the right of the approving entity to initiate an action without a recommendation.

Other:

Governing documents are documents which establish and describe an entity, including the purposes, the powers reserved to the members or shareholders, and which set forth the rights of partners or joint owners relative to each other. Governing documents include documents

filed with the state (such as articles or certificates of incorporation), bylaws (whether a corporation or an unincorporated division which has its own governing body), operating agreements and partnership agreements.

Key Bylaws Provisions are variations from the standard Governing Documents that concern any of the following: (a) the Ministry name and corporate purposes; (b) the Mission, Core Values and Catholic Identity of the Ministry and powers exercisable by CHM; (c) the identity of, reserved powers exercisable by and other matters pertaining to Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Ministry Board of Directors. All other variations are not Key Bylaw Provisions.

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
I	**Statements of Identity**					
I a	Trinity Health System Mission Statement	-	-	-		Approve
1 b	Trinity Health System Core Values	-	-	-		Approve
II	**Governing Documents**					
II a	Articles and Bylaws of Trinity Health Corporation	-	-	Recommend	Approve and Recommend	Ratify
II b	Governing Documents of Ministries consistent with standard form approved by Trinity Health Board	-	Approve and Recommend	Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel)	Approval of Governing Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions	-

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
II c	Governing Documents of Second Tier Subsidiary which operates licensed healthcare facilities consistent with standard form approved by Trinity Health Board	-	Approve and Recommend	Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel)	Approval of Governance Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions	-
II d	Governing Documents of Second Tier Subsidiary	Recommend	Approve	Approve		
III	**Appointments and Removals**					
III a	Appointment or removal of CHM Members (which comprise the Trinity Health Board of Directors)					Approve
III b	Appointment or removal of Trinity Health Board Chair				Approve	Ratify
III c	Appointment or removal Ministry Boards of Directors		Recommend	Recommend	Approve (Executive and Governance Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
III d	Appointment or removal of Ministry Board Chairs		Approve		Ratify (Executive and Governance Committee)	
III e	Appointment or removal of Second Tier Subsidiaries Governing Body	Recommend	Approve			
III f	Appointment or removal of Trinity Health CEO				Approve	Ratify
III g	Appointment or removal of Ministry CEOs	Participate	Recommend	Approve		
III h	Appointment or removal of Second Tier Subsidiaries CEOs	Approve				
IV	**Strategy**					
IV a	Trinity Health System Strategic Plans			Recommend	Approve	
IV b	Group I RHM and NHM Strategic Plans	Recommend	Approve	Approve		
IV c	Group 2 RHM and MHM Strategic Plans	Recommend	Approve	Participate		

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V	**Finance Matters**					
V a	Group I RHM and NHM Capital Acquisitions and Dispositions	Recommend	Approve up to 2% of net assets with a maximum of $5million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	Approval as required by Canon Law
V b	Group II RHM and MHM Capital Acquisitions and Dispositions	Recommend	Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	Approval as required by Canon Law
V c	Additional Debt and System Five Year Plan of Finance			Recommends	Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V d	System Operating and Capital Budget			Recommend	Approve (upon recommendation by Stewardship Committee)	
V e	RHM Operating and Capital Budget	Recommend	Approve	Approve		
V f	Second Tier Operating and Capital Budget	Recommend	Approve			
V g	Contracts (including leases) in which the Trinity Health is the financially obligated			Approve up to $25 million	Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee)	
V h	Contracts (including leases) in which a Group I RHM or a NHM is financially obligated	Recommend	Approve up to 2% of net assets with a maximum of $5million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
V i	Contracts (including leases) in which a Group II RHM or MHM is financially obligated	Recommend	Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million	Approve above the RHM Governance level up to $25 million	Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee)	
V j	Auditor Selection (Trinity Health System and separate audits)			Recommend	Approve (upon recommendation by the Audit Committee)	
V k	Annual Trinity Health System Audit			Recommend	Approve (upon recommendation by the Audit Committee)	
VI	**New Organizations and Major Transactions**					
VI a	Major change affecting Trinity Health (merger, consolidation, creation, transfer, sale of substantially all assets)			Recommend	Approve	Approve

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VI b	Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) not related to an Trinity Health System reorganization	Recommend	Recommend (Approve if required by State law)	Recommend	Approve	Approve as related to Sponsorship obligations
VI c	Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) related to a Trinity Health System reorganization	Recommend	Recommend (Approve if required by State law)	Recommend	Stewardship Committee Approve	Approve as related to Sponsorship obligations
VI d	Major change affecting Second Tier Subsidiaries (merger, consolidation, creation, transfer, sale of all assets)	Recommend	Approve	Approve		Approve as related to Sponsorship obligations
VI e	Internal operational reorganization affecting tier structure	Participate	Recommend	Approve		

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VI f	Formation or acquisition of an entity in which Trinity Health will be the sole parent			Recommend	Approve	Approve as related to Sponsorship obligations
VI g	Joint venture or other enterprise affecting ownership of a Group I RHM or NHM	Recommend	Approve	Recommend	Approve	Approve as related to Sponsorship obligations
VI h	Joint venture or other enterprise affecting ownership of a Group II RHM or MHM	Recommend	Approve	Recommend	Approval by Stewardship Committee	Approve as related to Sponsorship obligations
VII	**People Centered Care**					
VII a	Trinity Health System Wide Quality and Safety Standards	Participates		Recommends	Approves (upon recommendation of the People Centered Care Committee	

	Action	Ministry Management	Ministry Governance	Trinity Health Management	Trinity Health Governance	Catholic Health Ministries
VII b	RHM Quality and Safety Standards (consistent with Trinity Health System Quality Standards)	Recommends	Approves			
VII c	Annual review of Trinity Health System Quality and Safety			Recommends	People Centered Care Committee Approves, Board Receives Report	
VII d	Annual review of RHM Quality and Safety	Recommends	Approves	Receive Report		

EXIHIBIT A

MINISTRIES
Based on the FY 2014 Income Statement

REGIONAL HEALTH MINISTRIES (RHMs) – GROUP I

Holy Cross Health (Maryland)
Holy Cross Hospital (Florida)
Loyola University Health System (Illinois)
Mercy Health (Michigan)
Mercy Health Services – Iowa (Iowa)
Mercy Health System of Southeastern Pennsylvania (Pennsylvania)
Mount Carmel Health System (Ohio)
Our Lady of Lourdes Health Care Services (New Jersey)
Saint Agnes Medical Center (California)
Saint Alphonsus Health System (Idaho)
Saint Joseph Mercy Health System (Michigan)
Saint Joseph Regional Medical Center (Indiana)
Sisters of Providence Health System (Massachusetts)
St. Mary Medical Center (Pennsylvania)
St. Mary's Health Care System (Georgia)
St. Peter's Health Partners (New York)

REGIONAL HEALTH MINISTRIES (RHMs) – GROUP II

Mercy Health System of Chicago (Illinois)
Saint James Mercy Health System (New York)
Saint Michael's Medical Center (New Jersey)
St. Francis Hospital (Delaware)
St. Francis Medical Center (New Jersey)

NATIONAL HEALTH MINISTRIES (NHMs)

Trinity Home Health Services (multi-state)
Trinity Senior Living Communities (multi-state)
Trinity PACE

MISSION HEALTH MINISTRIES (MHMs)

Allegany Franciscan Ministries (Florida)
Global Health Ministry (Pennsylvania)
Mercy Medical (Alabama)
Pittsburgh Mercy Health System (Pennsylvania)
Saint Joseph's Health System (Georgia)

Approved by Trinity Health Executive and Governance Committee 6/18/14, effective 7/1/14; revised and approved by the Trinity Health Executive and Governance Committee on January 27, 2015; revised and approved by the Trinity Health Board of Directors on February 25, 2015; revised and approved by the Trinity Health Executive and Governance Committee on April 9, 2015; approved by Catholic Health Ministries on June 25, 2015.

EXHIBIT D

SAINT MARY'S HOSPITAL, INC. AMENDED AND RESTATED CERTIFICATE OF INCORPORATION AND AMENDED AND RESTATED BYLAWS

[SEE ATTACHED]

Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

ARTICLE I

Name

The name of the Corporation is Saint Mary's Hospital, Inc.

ARTICLE II

Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

ARTICLE III

Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on

behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

ARTICLE IV
Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE V

Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

ARTICLE VI

Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

ARTICLE VII

Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable

law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

ARTICLE VIII

Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a

member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX

Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

ARTICLE X

Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

BYLAWS

OF

SAINT MARY'S HOSPITAL, INC.

A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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ARTICLE I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

(i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or

(ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

Article II. PURPOSES

Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the Ethical and Religious Directives for Catholic Health Care Services as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

ARTICLE III. MEMBER

Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

Section 3.02 Member Authority

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

Section 3.03 Reserved Powers of Trinity Health

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

Section 3.04 Meetings of the Member

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

ARTICLE IV. BOARD OF DIRECTORS

Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the

Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation (who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

Section 4.03 Term

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

Section 4.04 Annual Meeting of the Board of Directors

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

Section 4.05 Regular Meetings and Notice

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

Section 4.06 Special Meetings and Notice

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

Section 4.07 Waiver of Notice

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

Section 4.08 Quorum and Valid Director Action

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

Section 4.09 Written Consents

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

Section 4.10 Communication Equipment

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 4.11 Resignation

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

Section 4.12 Removal

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

Section 4.13 Periodic Performance Review

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

ARTICLE V. MEDICAL/DENTAL STAFF

Section 5.01 Medical/Dental Staff Bylaws

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

Section 5.02 Medical/Dental Staff of Operating Units

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

ARTICLE VI. COMMITTEES

Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective

committees through the next annual meeting or until their successors are appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

Section 6.04 Quorum, Meetings, Rules and Procedures

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

Section 6.05 Committee Composition

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

ARTICLE VII. OFFICERS

Section 7.01 Officers

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time. Officers shall hold their respective offices until their successors are chosen and qualified.

Section 7.02 Appointment and Election of Officers

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The

Chair shall serve a term of one (1) year and may be elected for a total of three (3) consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

Section 7.03 Vacancies

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

Section 7.04 Chair

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

Section 7.05 President

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

Section 7.06 Secretary

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

Section 7.07 Treasurer

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such

delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

ARTICLE VIII. INDEMNIFICATION AND STANDARD OF CARE

Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 8.04 Justifiable Reliance

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 8.05 Consideration of Factors

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 8.06 Presumption

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

Section 8.07 Personal Liability of Directors

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

ARTICLE IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

ARTICLE X. OPERATING UNITS

Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

Article XI. MISCELLANEOUS

Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time

required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

Section 11.03 Confidentiality

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

Section 11.04 Conflict of Interest

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

ARTICLE XII. AMENDMENT AND REVIEW

Section 12.01 Amendment

These Bylaws may be amended only in accordance with Article III of these Bylaws.

Section 12.02Periodic Review

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

DISCLOSURE SCHEDULE

This Disclosure Schedule (this "Disclosure Schedule") is being delivered pursuant to the terms of that certain Membership Transfer Agreement (the "Agreement"), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation ("Trinity Health"), Saint Francis Care, Inc., a Connecticut nonstock corporation ("NE-RHM"), and Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital, Inc. ("SMH"), both Connecticut nonstock corporations (collectively, "Saint Mary's"). The substitution of NE-RHM for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A .....Knowledge of Saint Mary's

Schedule 1B .....Knowledge of NE-RHM

Schedule 1C .....Knowledge of Trinity Health

Schedule 2.01..... Board of Directors and Officers of SMH

Schedule 3.02.....Board of Directors and Officers of RHM

Schedule 6.04.....Conflicts/Consents

Schedule 6.05.....Organizational Chart

Schedule 6.08.....Absence of Certain Changes, Events and Conditions

Schedule 6.09(a) .....Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries

Schedule 6.09(c) .....Material Contracts

Schedule 6.10.....Permitted Encumbrances

Schedule 6.12(a) .....Owned Real Property/Encumbrances

Schedule 6.12(b) .....Leased Real Property

Schedule 6.14(a) .....Legal Proceedings

Schedule 6.14(b) .....Governmental Orders, Judgments, Penalties, Awards

Schedule 6.15(a) .....Compliance With Laws/Permits

Schedule 6.16(a) .....Government Program Survey Reports

Schedule 6.16(b) .....Reimbursement Claims

Schedule 6.16(d) .....Accreditation Survey Report and Deficiency List

Schedule 6.19.....Breach Notifications

Schedule 6.22(a) .....Employee Benefit Plans

Schedule 6.22(c) .....Employee Pension Benefit Plans

Schedule 6.22(d) .....Multiemployer Plans

Schedule 6.22(e) .....Church Plans

Schedule 6.22(f).....Employee Welfare Benefit Plans

Schedule 6.22(g) .....Agreements with Employees, Etc.

Schedule 6.22(h) .....Prohibited Transactions

Schedule 6.22(k) .....Nonqualified Deferred Compensation Plans

Schedule 6.23.....Collective Bargaining Agreements; Threats of Strike, Slowdown, etc.

Schedule 6.24 .....Tax Returns, Tax Payments
Schedule 6.25 .....Insurance Policies
Schedule 7.04 .....Conflicts/Consents
Schedule 7.08(a) .....Compliance with Laws
Schedule 7.09(a) .....Government Program Survey Reports
Schedule 7.09(b) .....Reimbursement Claims
Schedule 7.12 .....Breach Notification
Schedule 8.08(a) .....Owned Real Property

DISCLOSURE SCHEDULE

This Disclosure Schedule (this **"Disclosure Schedule"**) is being delivered pursuant to the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of _____, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Saint Francis Care, Inc., a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**). The substitution of **NE-RHM** for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to **NE-RHM and** Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A _____	Knowledge of Saint Mary's
Schedule 1B _____	Knowledge of NE-RHM
Schedule 1C _____	Knowledge of Trinity Health
Schedule 3.02 _____	Board of Directors of NE-RHM - Saint Mary's Members
Schedule 6.04 _____	Conflicts/Consents
Schedule 6.05 _____	Organizational Chart
Schedule 6.07 _____	Undisclosed Liabilities
Schedule 6.08 _____	Absence of Certain Changes, Events, Conditions
Schedule 6.09 _____	Material Contracts
Schedule 6.09(c) _____	Material Contracts - Validity
Schedule 6.10 _____	Permitted Encumbrances
Schedule 6.11 _____	Condition and Sufficiency of the Saint Mary's Assets
Schedule 6.12(a) _____	Owned Real Property
Schedule 6.12(b) _____	Leased Real Property
Schedule 6.14(a) _____	Legal Proceedings
Schedule 6.14(b) _____	Governmental Orders
Schedule 6.15(a) _____	Compliance With Laws
Schedule 6.16(a) _____	Medicare - Plans of Correction
Schedule 6.16(b) _____	Medicare - Claims
Schedule 6.16(d) _____	Medicare - Accreditation Surveys/Deficiency List
Schedule 6.19 _____	HIPAA - Breach Notifications
Schedule 6.20 _____	Affiliate Transactions
Schedule 6.21(e) _____	Environmental
Schedule 6.22(a) _____	Employee Benefit Plans
Schedule 6.22(b) _____	Benefit Plans - Compliance
Schedule 6.22(c) _____	Employee Pension Benefit Plan Liability
Schedule 6.22(d) _____	Multiemployer Plan Liability
Schedule 6.22(e) _____	Church Plans
Schedule 6.22(f) _____	Employee Welfare Benefit Plans
Schedule 6.22(g) _____	Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans
Schedule 6.23 _____	Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

Schedule 1A

Knowledge of Saint Mary's

1. Chad Wable, CEO
2. Ralph Becker, CFO
3. Chip Flynn, COO
4. Steve Schneider, MD, Chief Medical Officer, President of Franklin Medical Group

Schedule 1B

Knowledge of NE-RHM

1. Christopher M. Dadlez, President and CEO
2. John Rodis, Executive Vice President and COO
3. David Bittner, Senior Vice President of Finance, CFO
4. Janeanne C. Lubin-Szafranski, Vice President and General Counsel
5. Jennifer S. Schneider, Vice President of Finance

Schedule 1C

Knowledge of Trinity Health

1. James R. O'Connell, Executive Vice President
2. Paul Neumann, Executive Vice President and General Counsel
3. Benjamin Carter, Executive Vice President and CFO
4. Michael Holper, Senior Vice President

Schedule 2.01

SMH Board Members

The initial members of the SMH Board will be identified by the Parties prior to the Closing Date

Schedule 3.02

Board of Directors of NE-RHM - Saint Mary's Members

To be identified by Parties prior to the Closing Date

Schedule 6.04

Conflicts/Consents

(a) None.

(b)

OHCA CON Order, Docket No. 08-31202. Condition 2(b) to the Order provides that the Heart Center's CON authorization will become invalid and therefore null and void if, "any changes in the ownership or control of one or both of the legal entities, [Saint Mary's Hospital or the Waterbury Hospital]" occur. Saint Mary's and Waterbury Hospital are in the process of filing a CON Modification requesting that OHCA vacate Condition 2(b).

(c)(i)

(1) Waterbury Hospital pursuant to Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999, the Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003, and the bylaws of both Harold Leever and the Heart Center.

(2) Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

(3) Connecticut Department of Social Services Health Care Financing - Provider Enrollment Agreement, dated 3/12/09, between CT DSS and Saint Mary's Hospital. Re-enrollment requires notification

(4) Craneware License and Service Agreement, dated 4/29/13, between Craneware plc and Saint Mary's Hospital. Assignment, which includes change of ownership, requires consent.

(5) McKesson Premier Member Letter of Participation, dated 12/16/13, between McKesson and Saint Mary's Health System, Inc. Notice required on change of ownership.

(6) The following consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Saint Mary's Hospital or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby:

a. Roman Catholic Archdiocese of Hartford
b. Holy See, Roman Catholic Church
c. State of Connecticut Office of Healthcare Access
d. Office of the Attorney General of the State of Connecticut
e. Federal Trade Commission

(7) Consent may be required with respect to Diagnostic Imaging of Southbury, LLC

(c)(ii) None.

(c)(iii) None.

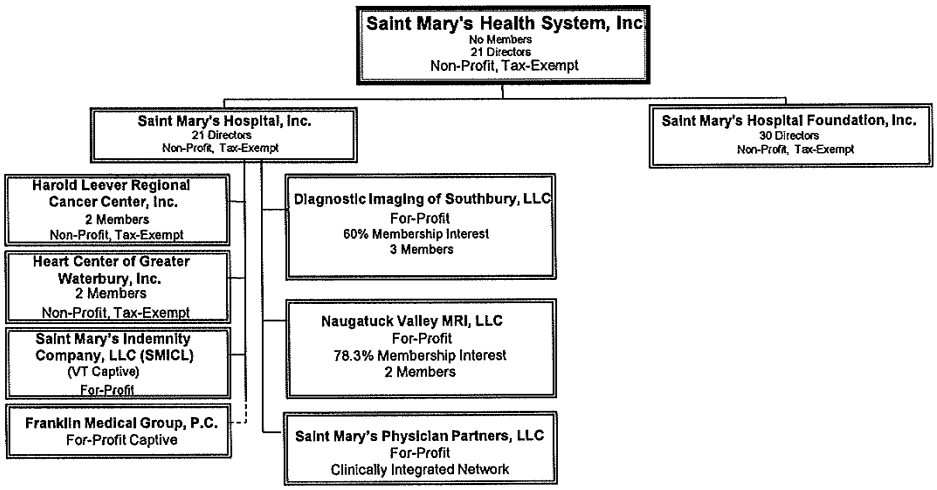
(c)(iv) None.

(c)(v)

1. Master Service Agreement, dated 1/5/09, between Connecticut Children's Medical Center and Saint Mary's Hospital, Inc.

Schedule 6.05

Organizational Chart



August 2015

Schedule 6.07

Undisclosed Liabilities

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000

2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.

3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.

4. Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

   Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

Schedule 6.08

Absence of Certain Changes, Events, Conditions

6.08(a):

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.08(b):

Saint Mary's is in the process of converting Franklin Medical Group to a Medical Foundation.

6.08(c): None

6.08(d): None

6.08(e): None

6.08(f): None

6.08(g): None

6.08(h): None

6.08(i): None

6.08(j):

An electrical transformer failed in July 2015. Replacement of the transformer itself and associated labor are expected to be greater than $100,000. Incident has not been submitted to

insurance. Awaiting final invoices from contractor.

6.08(k):

The receivable for $315k as of June 30, 2015 for CVS retail pharmacy will be written off by end of year. The retail pharmacy program started in April FY15. The program is being discontinued. Approximately $165k was accrued for expenses associated with these revenues. Those will also be released to income. The net impact to the income statement will be approximately $150k.

SMH capitalized $904k worth of fixed asset additions in the month of July. Cath Lab equipment ($190k) and build out of West Main Urgent Care ($151k) were included.

6.08(l): None

6.08(m): None

6.08(n): None

6.08(o): None

6.08(p): None

6.08(q): None

6.08(r): None

Schedule 6.09

Material Contracts

(i) Each Contract involving aggregate consideration in excess of $100,000

See attached.

(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000

1. Asset Purchase Agreement by and among Saint Mary's Hospital, Inc. and Joseph Bowen, M.D., dated June 1, 2014

2. Asset Purchase Agreement by and among Franklin Medical Group, P.C. and Digestive Disease Center of CT, LLC, dated May 23, 2014

(iii) All Contracts with any Governmental Authority

1. Student Educational Affiliation Agreement between Waterbury Department of Education and Saint Mary's Hospital, July 27, 2007

2. Provider Enrollment Agreement between Connecticut Department of Social Services and Saint Mary's Hospital, dated March 3, 2009

3. Board of Trustees of Community-Technical Colleges on behalf of Northwestern Connecticut Community College, dated January 3, 2011

4. Student Educational Affiliation Agreement between University of Connecticut, School of Social Work and Saint Mary's Hospital, dated January 17, 2011

5. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Franklin Medical Group, dated October 14, 2011

6. Educational Agreement between the University of Connecticut School of Medicine and Saint Mary's Hospital, dated December 20, 2011

7. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated November 7, 2012

8. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated November 21, 2012

9. In-State Student Affiliation Agreement between University of Connecticut, Department of Allied Health Sciences and Saint Mary's Hospital, dated January 1, 2013

10. In-State Student Affiliation Agreement between University of Connecticut School of Nursing and Saint Mary's Hospital, dated January 2, 2013

11. Child Day Care License between State of Connecticut Department of Public Health and Saint

Mary's Hospital, dated March 20, 2013

12. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 22, 2013

13. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated May 5, 2013

14. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated June 19, 2013

15. Purchase of Service Contract between Department of Public Health and Saint Mary's Hospital, dated July 1, 2013

16. Student Education Affiliation Agreement between Western Connecticut State University and Saint Mary's Hospital, dated September 7, 2013

17. Contract between Board of Regents for Higher Education on behalf of Gateway Community College and Saint Mary's Hospital, dated October 22, 2013

18. Student Education Affiliation Agreement between Central Connecticut State University and Saint Mary's Hospital, dated October 28, 2013

19. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 4, 2014

20. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated February 6, 2015

21. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, Inc., dated February 20, 2015

22. In-State Student Educational Training Affiliation Agreement between University of Connecticut, Department of Kinesiology and Saint Mary's Hospital, dated May 28, 2015

23. Agreement between City of Waterbury and Saint Mary's Hospital Child Development Center (pending City signature)

(iv) **Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement**

1. Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999.

2. Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003

3. Operating Agreement of Southbury Diagnostic Imaging Center, LLC, dated October 7, 1998

4. Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

5. Affiliation Agreement among The Waterbury Hospital and St. Mary's Hospital, dated December 22, 2003

(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand

1. Cardiac Anesthesia Services Agreement between the Heart Center of Greater Waterbury, Inc. and Saint Mary's Hospital Inc., dated October 2007
2. Operating Agreement of Saint Mary's Physician Partners, LLC, dated June 27, 2014
3. Operating Agreement of Saint Mary's Indemnity Company, LLC, dated July 1, 2009
4. Services Agreement by and between the Harold Leever Regional Cancer Center, Inc., and Saint Mary's Hospital, dated October 9, 2002
5. Emergency Department Services Agreement by and between Saint Mary's Hospital and Franklin Medical Group, P.C., dated May 1, 2003
6. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003
7. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003
8. Cardiology Services Agreement by and between Waterbury Heart Center, Inc., St. Mary's Hospital, and Waterbury Hospital, and Cardiology Associates of Waterbury, P.C., dated November 1, 2004

(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party

None.

(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000
2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.
3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.
4. Master Lease Agreement by and between Saint Mary's Hospital and De Lage Landen Financial Services, Inc., dated December 28, 2009, as amended

SAINT MARY'S HOSPITAL CONTRACTS

MASTER COMMERCIAL CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1002C	Saint Mary's Hospital	Geonetric Technology
1001.1007E	Saint Mary's Hospital	McKesson Corporation
1001.1008E	Saint Mary's Hospital	McKesson Corporation
1001.1009E	Saint Mary's Hospital	McKesson Corporation
1001.1012C	Saint Mary's Hospital	McKesson Corporation
1001.1016C	Saint Mary's Hospital	Medtronic, Inc.
1001.1017C	Saint Mary's Hospital	Medtronic, Inc.
1001.1019C	Saint Mary's Hospital	Quinnipiac University
1001.1024E	Saint Mary's Hospital	Nuance Powerscribe
1001.1025E	Saint Mary's Hospital	Naugatuck Valley Community College
1001.1050C	Saint Mary's Hospital	RelayHealth
1001.1053C	Saint Mary's Hospital	RelayHealth
1001.1054C	Saint Mary's Hospital	Connecticut Hospital Association
1001.1060C	Saint Mary's Hospital	Roche Diagnostics Corporation
1001.1063E	Saint Mary's Hospital	Nuance Communications, Inc.
1001.1064E	Saint Mary's Hospital	McKesson Corporation
1001.1065C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1071C	Saint Mary's Hospital	Leidos Health LLC
1001.1083C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1085C	Saint Mary's Hospital	JVK Operations
1001.1092C	Saint Mary's Hospital	WB Mason
1001.1099C	Saint Mary's Physician Partners, LLC	Naugatuck Valley Women's Health Specialists, PC
1001.1100E	Saint Mary's Hospital	Wellsoft Corporation
1001.1119C	Saint Mary's Hospital	Healthstream, Inc.
1001.1120C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1121C	Saint Mary's Hospital	Allscripts Healthcare, LLC
1001.1160C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.1161C	Saint Mary's Hospital	Spirit of Women Health Network
1001.1165C	Saint Mary's Hospital	Kronos
1001.1168C	Saint Mary's Hospital	Siemens Healthcare Diagnostics Inc.
1001.1171C	Saint Mary's Hospital	Grainger Industrial Supply
1001.1173C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.1177C	Saint Mary's Hospital	Truven Health
1001.1178C	Saint Mary's Hospital	Spendadvisor

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1185C	Saint Mary's Hospital	Universal Background Screening
1001.1187C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1188C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1189C	Saint Mary's Hospital	Intuitive Surgical, Inc.
1001.1191C	Saint Mary's Hospital	Beckman Coulter
1001.1193C	Saint Mary's Hospital	Draeger Medical, Inc.
1001.1194C	Saint Mary's Hospital	Carl Zeiss Incorporated
1001.1204C	Saint Mary's Hospital	Cross Country Staffing
1001.1221C	Saint Mary's Hospital	Bard Peripheral Vascular, Inc.
1001.1225C	Saint Mary's Hospital	NVMRI
1001.1226C	Saint Mary's Hospital	Edwards Lifesciences LLC
1001.1231C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.1237C	Saint Mary's Hospital	Covidien Sales, LLC
1001.1248C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1250C	Saint Mary's Hospital	St. Jude Medical
1001.1274C	Saint Mary's Hospital	PMA Management Corp. of New England
1001.1275C	Saint Mary's Hospital	Neuro Enterprises, LLC
1001.1286C	Saint Mary's Hospital	Baxter Healthcare Corporation
1001.1294C	Saint Mary's Hospital	Covidien
1001.190C	Saint Mary's Hospital	St Jude Medical US Division
1001.204E	Saint Mary's Hospital	Stericycle, Inc.
1001.210C	Saint Mary's Hospital	Craneware, Inc.
1001.216C	Saint Mary's Hospital	University of Connecticut School of Medicine
1001.219C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.228C	Saint Mary's Hospital	Naugatuck Valley Lawn Maintenance, Inc.
1001.235E	Saint Mary's Hospital	School Readiness Grant Program
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.287C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.304E	Saint Mary's Hospital	Stryker
1001.332C	Saint Mary's Hospital	Heart Center of Greater Waterbury, Inc.
1001.354E	Saint Mary's Hospital	Sodexho Operations, LLC
1001.367E	Saint Mary's Hospital	Yale University School of Medicine
1001.393C	Saint Mary's Hospital	3M Health Care Service Center
1001.411C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.418E	Saint Mary's Hospital	TPC Associates, Inc.
1001.420C	Saint Mary's Hospital	Western Connecticut State University
1001.427C	Saint Mary's Hospital	Sodexho Operations, LLC
1001.430C	Saint Mary's Hospital	Yale University School of Medicine

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.433C	Saint Mary's Hospital	Yale University School of Medicine
1001.444C	Saint Mary's Hospital	Northwestern Connecticut Community College
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.468C	Saint Mary's Hospital	University of Connecticut, Department of Allied Health Sciences
1001.469C	Saint Mary's Hospital	University of Connecticut School of Nursing
1001.474C	Saint Mary's Hospital	Haemonetics Corporation
1001.47C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.482C	Saint Mary's Hospital	Department of Public Health
1001.489C	Saint Mary's Hospital	Gateway Community College
1001.490C	Saint Mary's Hospital & Health System	Santa Buckley Energy, Inc.
1001.495E	Saint Mary's Hospital	GE Healthcare
1001.519C	Saint Mary's Hospital	University of Connecticut School of Social Work
1001.521C	Saint Mary's Hospital	Department of Social Services
1001.525C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.527E	Saint Mary's Hospital	Connecticut Light and Power Company
1001.541C	Saint Mary's Hospital	Waterbury Department of Education
1001.545C	Saint Mary's Hospital	Healthstream, Inc.
1001.54C	Saint Mary's Hospital	3M Health Care Service Center
1001.590C	Saint Mary's Hospital	bioMerieux, Inc.
1001.592C	Saint Mary's Hospital	American National Red Cross
1001.603C	Saint Mary's Hospital	Unitex Textile Rental Services
1001.608C	Saint Mary's Hospital	City-Wide Delivery Service, Inc.
1001.632C	Saint Mary's Hospital	McKesson Health Solutions, LLC
1001.633E	Saint Mary's Hospital	Otis Elevator Company
1001.653C	Saint Mary's Hospital	Siemens Industry, Inc.
1001.668C	Saint Mary's Hospital	Yale University School of Medicine
1001.676E	Saint Mary's Hospital	SkillSurvey
1001.679C	Saint Mary's Hospital	3M Health Care Service Center
1001.681C	Heart Center of Greater Waterbury	University of Connecticut Health Center Department of Finance
1001.682C	Saint Mary's Hospital	Med3000, Inc.
1001.688C	Saint Mary's Hospital	Yale University School of Medicine
1001.691C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.694C	Saint Mary's Hospital	Healthstream, Inc.
1001.749C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.750C	Saint Mary's Hospital	Connecticut Light and Power Company

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.768C	Saint Mary's Health System	Axiom Group, LLC
1001.783C	Saint Mary's Hospital	Best Practices, Inc.
1001.785C	Saint Mary's Hospital	MedAssets Net Revenue Systems, LLC
1001.786C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.787E	Saint Mary's Hospital	GE Medical Systems
1001.788C	Saint Mary's Hospital	Financial Health Strategies, Inc.
1001.811C	Saint Mary's Hospital	Department of Public Health
1001.814C	Saint Mary's Hospital	Executive Health Resources, Inc. (E.H.R.)
1001.820E	Saint Mary's Hospital	Dell
1001.8221C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.822C	Saint Mary's Hospital	Healthstream, Inc.
1001.825E	Saint Mary's Hospital	Diagnostic Equipment Service Corporation (DESCO)
1001.829C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.840C	Saint Mary's Hospital	University of Connecticut School of Allied Health
1001.852C	Saint Mary's Hospital	Bay State Anesthesia
1001.853C	Saint Mary's Hospital	Department of Public Health
1001.858C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.860C	Saint Mary's Hospital	Syntrac Cardinal Health
1001.861C	Saint Mary's Hospital	Sunquest Information Systems, Inc.
1001.866C	Saint Mary's Health System	VPNE Parking Solutions, LLC
1001.882C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.883C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.884C	Saint Mary's Hospital	Olympus America, Inc.
1001.886C	Saint Mary's Hospital	Telephone Nurse Triage - Kanagaratnam Jegathesan, MD
1001.890E	Saint Mary's Hospital	Corepoint
1001.891C	Saint Mary's Hospital	Advantage RN
1001.944C	Saint Mary's Hospital	RelayHealth
1001.950C	Saint Mary's Hospital	Xtend Healthcare, LLC
1001.962C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.979C	Saint Mary's Hospital	Yale University School of Medicine
1001.997C	Saint Mary's Health System, Inc.	McKesson Corporation
1002.1048C	Franklin Medical Group, P.C.	Nuance Communications, Inc.
1002.1090C	Franklin Medical Group, P.C.	Digestive Disease Center of CT, LLC
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1002.448C	Franklin Medical Group, P.C.	Department of Public Health
1002.530C	Franklin Medical Group, P.C.	Napiello, Virginia APRN
1002.572E	Franklin Medical Group, P.C.	Microsoft Licensing, GP

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.888E	Franklin Medical Group, P.C.	Phoenix Internal Medicine Associates, LLC
1002.958C	Franklin Medical Group, P.C.	VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc.
1002.959C	Franklin Medical Group, P.C.	Thames Records Management
1002.967C	Franklin Medical Group, P.C.	City-Wide Delivery Service, Inc.
1002.974C	Franklin Medical Group, P.C.	Intuitive Surgical, Inc.
1010.946C	Saint Mary's Hospital	Healthstream, Inc.
1010.966C	Saint Mary's Hospital	Healogics Wound Care & Hyperbaric Services, Inc.
1010.968C	Saint Mary's Hospital	Commerce Bank
1010.978C	Saint Mary's Hospital	Central Connecticut State University
1010.984E	Saint Mary's Hospital	Alliance Healthcare Services
1010.985C	Saint Mary's Hospital	Jackson & Coker Permanent, LLC

NON-PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.445C	Saint Mary's Hospital, Inc.	Union Square Southbury, LLC (Landlord)
2005.445C	Saint Mary's Hospital, Inc.	Associated Physicians of Southbury, P.C. (Subtenant)
2005.762C	Saint Mary's Hospital, Inc.	146 Highland Associates, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc.	1981 East Main Street, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc. (Sublandlord)	Inwelligent Healthcare, Inc. (Subtenant)
2007.104C	Saint Mary's Hospital, Inc.	Scovill Commons Partners, LLC (Landlord)
2007.1186E	Saint Mary's Hospital, Inc.	Subway Real Estate Corp. (Tenant)
2007.1227C	Saint Mary's Hospital, Inc.	Northwest CT Public Safety Communications Center Inc. (Tenant)
2007.245C	Saint Mary's Hospital Corporation	Spectrum Square, LLC (Landlord)
2007.273E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.285E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.330E	Saint Mary's Hospital, Inc.	500 Chase Parkway Condominium Association, Inc. (Landlord)
2007.345C	Saint Mary's Hospital, Inc.	Paolo Mappelli, M.D. (Landlord)
2007.509E	Saint Mary's Hospital Corporation	Scovill Commons Partners, LLC (Landlord)
2007.760C	Saint Mary's Hospital	JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord)
2007.761C	Saint Mary's Hospital	Park West, LLC (Landlord)

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2007.765E APPRAISAL/OPINION - NOT REVIEWED	N/A	N/A
2013.1129C	Franklin Medical Group, P.C.	1177, LLC (Landlord)

PROVIDER CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1072C	Saint Mary's Hospital	Singanamala, Santhi MD
1001.1082C	Saint Mary's Hospital	Waterbury Pulmonary Associates, LLC
1001.1105C	Saint Mary's Hospital	Brittny Williams Howell, MD
1001.110C	Saint Mary's Hospital	Martinucci, Erica MD
1001.1176C	Saint Mary's Physician Partners, LLC	
1001.1216C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.1298C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.323E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.342C	Saint Mary's Hospital	Consultants In Pathology, PC
1001.37C	Saint Mary's Hospital	Rho, Mira MD
1001.39C	Saint Mary's Hospital	Roer, David MD
1001.407C	Saint Mary's Hospital	Neurosurgery Orthopaedics & Spine Specialists PC
1001.783E	Saint Mary's Hospital	EmCare, Inc. AND EmCare, Inc.
1001.480C	Saint Mary's Hospital	Milford Anesthesia Associates, LLC
1001.543E	Saint Mary's Hospital	Koteles, Alicia MD
1001.547C	Saint Mary's Hospital	Raissi, Sina MD
1001.570C	Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership)	SurgiCenter Anesthesiologists, PC
1001.580C	Saint Mary's Hospital	Mayo Medical Laboratories
1001.593C	Saint Mary's Hospital	Zarif, Abdul MD
1001.68C	Saint Mary's Hospital	Zarif, Abdulmasih MD
1001.764C	Saint Mary's Hospital	Naugatuck Valley Women's Health Specialists, PC
1001.988E	Saint Mary's Hospital	Wellmore Behavioral Health
1002.1020C	Franklin Medical Group, P.C.	Monzurul Chowdhury, MD
1002.1022C	Franklin Medical Group, P.C.	Farah Chinwalla, DO
1002.1031C	Franklin Medical Group, P.C.	Bechoi Saleib, MD
1002.1037C	Franklin Medical Group, P.C.	Anna Freitag, MD
1002.1041C	Franklin Medical Group, P.C.	Lakshmi Polisetty, MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.1051C	Franklin Medical Group, P.C.	Frank Longo, MD
1002.1067C	Franklin Medical Group, P.C.	Ken Matsuo
1002.1069C	Franklin Medical Group, P.C.	Joseph Bowen, MD
1002.1101C	Franklin Medical Group, P.C.	Marano, Albert
1002.1102C	Franklin Medical Group, P.C.	Lyall, Bhupinder
1002.1103C	Franklin Medical Group, P.C.	Feinberg, Michael
1002.1104C	Franklin Medical Group, P.C.	Kraus, Mark, MD
1002.1107C	Franklin Medical Group, P.C.	Anupama Paranandi, MD Infectious Disease
1002.1109C	Franklin Medical Group, P.C.	Sallie Carrington, DO
1002.1110C	Franklin Medical Group, P.C.	Preissler, MD Paul
1002.1112C	Franklin Medical Group, P.C.	Garsten, MD Joel
1002.1113C	Franklin Medical Group, P.C.	Burlison, MD Kathleen
1002.1117C	Franklin Medical Group, P.C.	Cohen, Matthew, MD
1002.113C	Franklin Medical Group, P.C.	Palesty, J Alexander MD
1002.116C	Franklin Medical Group, P.C.	Wetmore, Robert S MD, PC
1002.117C	Franklin Medical Group, P.C.	Sieling, Beth Ann MD
1002.118C	Franklin Medical Group, P.C.	Sookhan, Nicole MD
1002.11C	Franklin Medical Group, P.C.	Rosenhein, Brian DO
1002.1208C	Franklin Medical Group, P.C.	Giacomazzi, Peter, MD
1002.120C	Franklin Medical Group, P.C.	Galal, Magdy MD
1002.1238C	Franklin Medical Group, P.C.	Shetty, MD Shohan
1002.1240C	Franklin Medical Group, P.C.	Albin, MD Dmitry
1002.1242C	Franklin Medical Group, P.C.	Neamtu, MD Andreea
1002.1268C	Franklin Medical Group, P.C.	Gork MD, Ahmet
1002.1269C	Franklin Medical Group, P.C.	Khan MD, Tasneem
1002.1270C	Franklin Medical Group, P.C.	Salerno MD, John
1002.1271C	Franklin Medical Group, P.C.	Polokoff MD, Ellen
1002.1272C	Franklin Medical Group, P.C.	Leal MD, Daniel
1002.1277C	Franklin Medical Group, P.C.	Medrano MD, Consuelito
1002.1278C	Franklin Medical Group, P.C.	Esemuede MD, Iyare
1002.1281C	Franklin Medical Group, P.C.	Thiruvengadam MD, Sudha
1002.12C	Franklin Medical Group, P.C.	Sheikh, Abdul Majeed MD
1002.1300C	Franklin Medical Group, P.C.	Carolyn O'Connor, MD
1002.1303C	Franklin Medical Group, P.C.	Greco, Thomas MD
1002.1304C	Franklin Medical Group, P.C.	Ann Marie Conti-Kelly, MD
1002.15C	Franklin Medical Group, P.C.	Te, Victorio Go MD
1002.18E	Franklin Medical Group, P.C.	Simms, Michael F MD
1002.20C	Franklin Medical Group, P.C.	Imam, Azhar MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.22C	Franklin Medical Group, P.C.	Nawaz, Shah MD
1002.23C	Franklin Medical Group, P.C.	Alston, Shawnette MD
1002.25C	Franklin Medical Group, P.C.	Beri, Rohit MD
1002.26C	Franklin Medical Group, P.C.	Bogursky, Sondra MD
1002.299C	Franklin Medical Group, P.C.	Anthony, J Robert MD
1002.29C	Franklin Medical Group, P.C.	Colodner, Gregory MD
1002.34C	Franklin Medical Group, P.C.	Newell, Rebecca O MD
1002.36C	Franklin Medical Group, P.C.	Ouellette, Jason MD
1002.379C	Franklin Medical Group, P.C.	Chere, Mitch MD
1002.3C	Franklin Medical Group, P.C.	Ramos, Rey MD
1002.41C	Franklin Medical Group, P.C.	Talwalkar, Jaideep MD
1002.42C	Franklin Medical Group, P.C.	Vaezy, Ali MD
1002.432C	Franklin Medical Group, P.C.	Ndiaye, Mouhamed A MD
1002.457C	Franklin Medical Group, P.C.	Gega, Arjet MD
1002.486C	Franklin Medical Group, P.C.	Chien, Peter MD
1002.493C	Franklin Medical Group, P.C.	Kelly, Paul MD
1002.501C	Franklin Medical Group, P.C.	Zhang, He MD
1002.503C	Franklin Medical Group, P.C.	Baba, Carolina Borz MD
1002.508C	Franklin Medical Group, P.C.	Rubenstein, Stephen MD
1002.513C	Franklin Medical Group, P.C.	Rovetto, Allyson MD
1002.515C	Franklin Medical Group, P.C.	Brenes, Laura C MD
1002.516C	Franklin Medical Group, P.C.	Zlotoff, Ronald A MD
1002.517C	Franklin Medical Group, P.C.	Singanamala, Swathi MD
1002.528C	Franklin Medical Group, P.C.	D'Souza, Bernard MD
1002.548E	Franklin Medical Group, P.C.	University of Connecticut Health Center
1002.55C	Franklin Medical Group, P.C.	Almeida, Carlos MD
1002.569C	Franklin Medical Group, P.C.	Richi, Maysoun MD
1002.56C	Franklin Medical Group, P.C.	Alvarez, Alexander J MD
1002.58C	Franklin Medical Group, P.C.	Testa, John MD
1002.59C	Franklin Medical Group, P.C.	Uberti, James G MD
1002.614C	Franklin Medical Group, P.C.	Richi, Aziz MD
1002.617C	Franklin Medical Group, P.C.	Toon, Claire DDS
1002.655C	Franklin Medical Group, P.C.	Quinn, Edmund
1002.685C	Franklin Medical Group, P.C.	Karen Kennedy
1002.69C	Franklin Medical Group, P.C.	Cardiology Associates of Waterbury, PC
1002.756C	Franklin Medical Group, P.C.	Zefirova, Julia MD
1002.758C	Franklin Medical Group, P.C.	Cumberland, Melisha MD
1002.763C	Franklin Medical Group, P.C.	Sanders, Tiffany MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.817C	Franklin Medical Group, P.C.	Mario Perez
1002.827E	Franklin Medical Group, P.C.	Seli, Meltem MD
1002.848C	Franklin Medical Group, P.C.	Albajrami, Oltjon MD
1002.879C	Franklin Medical Group, P.C.	Ranjan, Saurabh MD
1002.887C	Franklin Medical Group, P.C.	El-Hennawy, Magdy Sayed MD
1002.8C	Franklin Medical Group, P.C.	Hamill, Chalmers M MD
1002.915C	Franklin Medical Group, P.C.	Philip R. Corvo, MD
1002.93C	Franklin Medical Group, P.C.	Naugatuck Valley OBGYN PC
1002.943C	Franklin Medical Group, P.C.	Maria Dawe, MD
1002.961C	Franklin Medical Group, P.C.	Macaron, Shady Hafez MD
1002.972C	Franklin Medical Group, P.C.	Naugatuck Valley Women's Health Specialists, PC
1002.987C	Franklin Medical Group, P.C.	Jennyffer Peralta, MD
1002.993C	Franklin Medical Group, P.C.	Aditi Mukherji, MD
1002.994C	Franklin Medical Group, P.C.	Richard Putnam, DMD
1002.995C	Franklin Medical Group, P.C.	Rebecca Scandrett, MD
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center

PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.364C	Saint Mary's Hospital	Saint Mary's Hospital
2007.1285C	Saint Mary's Hospital	LJL Properties, LLC
2007.296C	Saint Mary's Hospital	West Main Medical, LLC, a Connecticut limited liability company, as Landlord
2008.534C	Primary Care Partners, P.C.	Greater Waterbury Primary Care Associates, P.C., as Tenant

Schedule 6.09(c)

Material Contracts - Validity

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

Schedule 6.10

Permitted Encumbrances

See attached lien report, dated September 14, 2015, prepared by CT Lien Solutions for all entities in Saint Mary's Health System

Blanket liens in favor of the master trustee (#0001772303) and in favor of Baytree National Bank & Trust Company (#0002913889) will be released prior to closing

Schedule 6.11

Condition and Sufficiency of the Saint Mary's Assets

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

Schedule 6.12(a)

Owned Real Property

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

2. Parcel Two

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

3. Parcel Three

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

4. Parcel Four

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

5. <u>Parcel Five</u>

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

6. Parcel Six

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

7. Parcel Seven

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

8. Parcel Eight

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

9. Parcel Nine

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

10. Parcel Ten

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

11. Parcel Eleven

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

12. Parcel Twelve

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

13. Parcel Thirteen

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

14. Parcel Fourteen

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

15. Parcel Fifteen

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

16. Parcel Sixteen

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

17. Parcel Seventeen

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

18. Parcel Eighteen

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

NORTHERLY:	79 feet on East Main Street
EASTERLY:	136 feet on Second Piece;
SOUTHERLY:	on land now or formerly of The Church of the Immaculate Conception; and
WESTERLY:	136 feet on land now or formerly of The Church of the Immaculate Conception.

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

NORTHERLY:	28.00 feet, more or less, by East Main Street;
EASTERLY:	130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street;
SOUTHERLY:	20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and
WESTERLY:	136.00 feet by land of Philip Avery.

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

NORTHEASTERLY:	19.86 feet by East Main Street;
SOUTHEASTERLY:	136.00 feet by land now or formerly of Philip Veillette, et al;
NORTHEASTERLY:	again 99.25 feet by land now or formerly of Philip Veillette, et
SOUTHEASTERLY:	al; again 43 feet, more or less, by Baldwin Street, fka Mill
SOUTHEASTERLY:	Street; again
SOUTHWESTERLY:	by Baldwin Street, fka Mill Street;
NORTHWESTERLY:	251.25 feet by land now or formerly of the Church of the Immaculate Conception; 136.68 feet by land now or formerly of the Church of the Immaculate Conception.

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

Schedule 6.12(b)

Leased Real Property

1. Lease Agreement by and between 1981 East Main Street LLC and Saint Mary's Hospital, Inc. dated May 18, 2010 for property located at 1981 East Main Street, Waterbury, Connecticut.

2. Agreement of Lease, by and between Crosspointe Plaza LLC and Saint Mary's Hospital dated August 18, 2000 for property known as the off-site Naugatuck Walk–In at Crosspointe Plaza Unit Numbers A1 and A2, as amended by the First Amendment to Lease dated April 27, 2009.

3. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, First Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

4. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, Lower Level, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

5. Lease by and between The Slocum Corporation and Saint Mary's Hospital Corporation dated October 1, 2002 for property at the medical building located at Scovill Street and Cole Street.

6. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital, Inc. dated November 18, 2005 for property located at 95 Scovill Street, Pavilion B, Second Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated September 10, 2007.

7. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital Corporation dated March 1, 2006 for property located at 95 Scovill Street, Pavilion B, Third Floor, Waterbury, Connecticut.

8. Lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006 for property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, as modified by the Lease Modification Agreement, dated January 1, 2009.

9. Commercial Lease by and between Metcalf Realty LLC and Saint Mary's Hospital, Inc. dated September 1, 2007 for property known as Bullet Hill Park and located at 33 Bullet Hill Road, Building A – Main Level, Southbury, Connecticut.

10. Lease by and between West Main Medical LLC and Saint Mary's Hospital, Inc. dated March 2004 for property located at 1312 West Main Street, Waterbury, Connecticut, as amended by the Amendment to Lease dated October 2004.

11. Indenture of Lease by and between Park West LLC and Saint Mary's Hospital dated March 21, 2002 for property located at 1320 West Main Street and Park Road in Waterbury, Connecticut, as amended by (i) the Amendment to Lease Agreement dated October 23, 2003 and (ii) the Second Amendment to Lease dated November 2004.

12. Lease by and between Spectrum Square LLC and Saint Mary's Hospital Corporation, Inc. dated February 24, 2004 for property located at 503 Wolcott Road, Second Floor, Wolcott, Connecticut, as amended by the Amended and Restated Lease dated April 1, 2006.

13. Lease by and between Southbury Properties Limited Partnership and Scovill Medical Group, P.C. dated February 1, 1997 for property known as the Union Square Shopping Center and located at Main Street South and Peter Road, Southbury, Connecticut, as modified by (i) the Sublease Agreement, dated May 1, 1998, (ii) the Amendment of Lease dated July 1999, (iii) the Amendment of Lease dated August 1, 1999, (iv) the Assignment of Leases and Security Deposits dated February 25, 2004 and (v) the Assignment, Third Amendment and Extension of Lease dated May 2006.

14. Commercial Lease Agreement by and between 146 Highland Associates LLC and Saint Mary's Hospital, Inc. dated January 2011 for property located at 146 Highland Avenue, Waterbury, Connecticut.

15. Lease Agreement by and between The Harold Leever Regional Cancer Center, Inc. and Saint Mary's Hospital, Inc., dated June 1, 2014 for property located at 1075 Chase Parkway, Waterbury, Connecticut.

16. Office Sublease Agreement by and between D'Vine Medical Spa LLC and Franklin Medical Group, P.C., dated September 30, 2013, for property located at 590 Middlebury Road, Middlebury, Connecticut.

17. Office Sublease Agreement by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

18. Office Lease Agreement by and between Prospect Medical, LLC, and Saint Mary's Hospital, Inc., dated December 1, 2010, for property located at 166 Waterbury Road, Suite 202, Prospect, Connecticut.

19. Lease Agreement by and between French's Mill Associates II LLP and Naugatuck Valley Surgical Center Limited Partnership, dated December 1, 2009, for property located at 160 Robbins Street, Waterbury, Connecticut

20. Indenture of Lease by and between Medical Investors L.L.C. and Saint Mary's Hospital, Inc., dated December 2, 2010 for property located at 70 Heminway Park Road, Watertown, Connecticut.

21. Lease Agreement by and between 1177, LLC and Franklin Medical Group, Inc., dated August 26, 2014, for property located at 1177 New Haven Road, Naugatuck, Connecticut.

22. Sublease Agreement by and between Westside Medical Group, P.C., and Franklin Medical Group, P.C., dated September 1, 2014, for property located at 714 Chase Parkway, Waterbury, Connecticut.

23. Lease by and between Edward I. Bushka and Margarita Bushka and Franklin Medical Group, dated July 22, 2014, for property located at 60 Westwood Avenue, Waterbury, Connecticut.

24. Lease by and between LJL Property, LLC, and Saint Mary's Hospital, Inc., dated June 17, 2015, for property located at 3528 East Main, Waterbury, Connecticut.

25. Lease by and between Bradley Medical Building Associates, L.L.C., and Franklin Medical Group, P.C., dated July 1, 2014, for property located at 55 Meriden Avenue, Suite 3C, Southington, Connecticut.

26. Lease by and between RPG Highland LLC and Saint Mary's Hospital, Inc., dated July 13, 2015, for property located at 1154 Highland Avenue, Cheshire, Connecticut.

27. Lease Agreement by and between Arev Three Limited Partnership and Ellen G. Polokoff, M.D., LLC, dated May 10, 2007, for property located at 900 Main Street South, Southbury, Connecticut, as amended by a First Amendment, dated September 30, 2009, a Second Amendment, dated November 30, 2011, and a Third Amendment, dated December 30, 2013. Ellen G. Polokoff M.D., LLC, assigned the lease to Franklin Medical Group, P.C., effective April 20, 2015.

28. Agreement of Lease by and between 385 Union Square Realty LLC and Comprehensive Health Care, LLC, dated October 2005, for property located at 385 Main Street South, Southbury, Connecticut, as amended by First Amendment, dated January 2009, and Second Amendment, dated April 2014. Agreement of Lease was assigned to Franklin Medical Group, P.C., effective July 31, 2015.

29. Office Lease, as amended, by and between Prospect Office LLC and Waterbury Primary Care Associates, P.C., dated December 2, 2004, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut. Office Lease assigned to Prospect Medical LLC, effective January 2008.

30. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

31. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Franklin Medical Group, P.C., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

Schedule 6.14(a)

Legal Proceedings

Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.

In each of the *Doe* matters, the plaintiffs allege that they were victims of sexual molestation perpetrated by the same priest while patients at Saint Mary's Hospital in the 1970s. The George Doe case was mediated before Judge Zemetis on June 30, 2015. The case was settled for $500,000 and will be paid in full by Travelers Insurance Company. Because the plaintiff was in bankruptcy, the settlement is subject to bankruptcy court approval. The remaining three *Doe* matters are being scheduled for mediation. Because Travelers filed a reservation of rights in 2008, Travelers has not affirmed coverage of the remaining three cases but is expected to provide coverage in full.

Schedule 6.14(b)

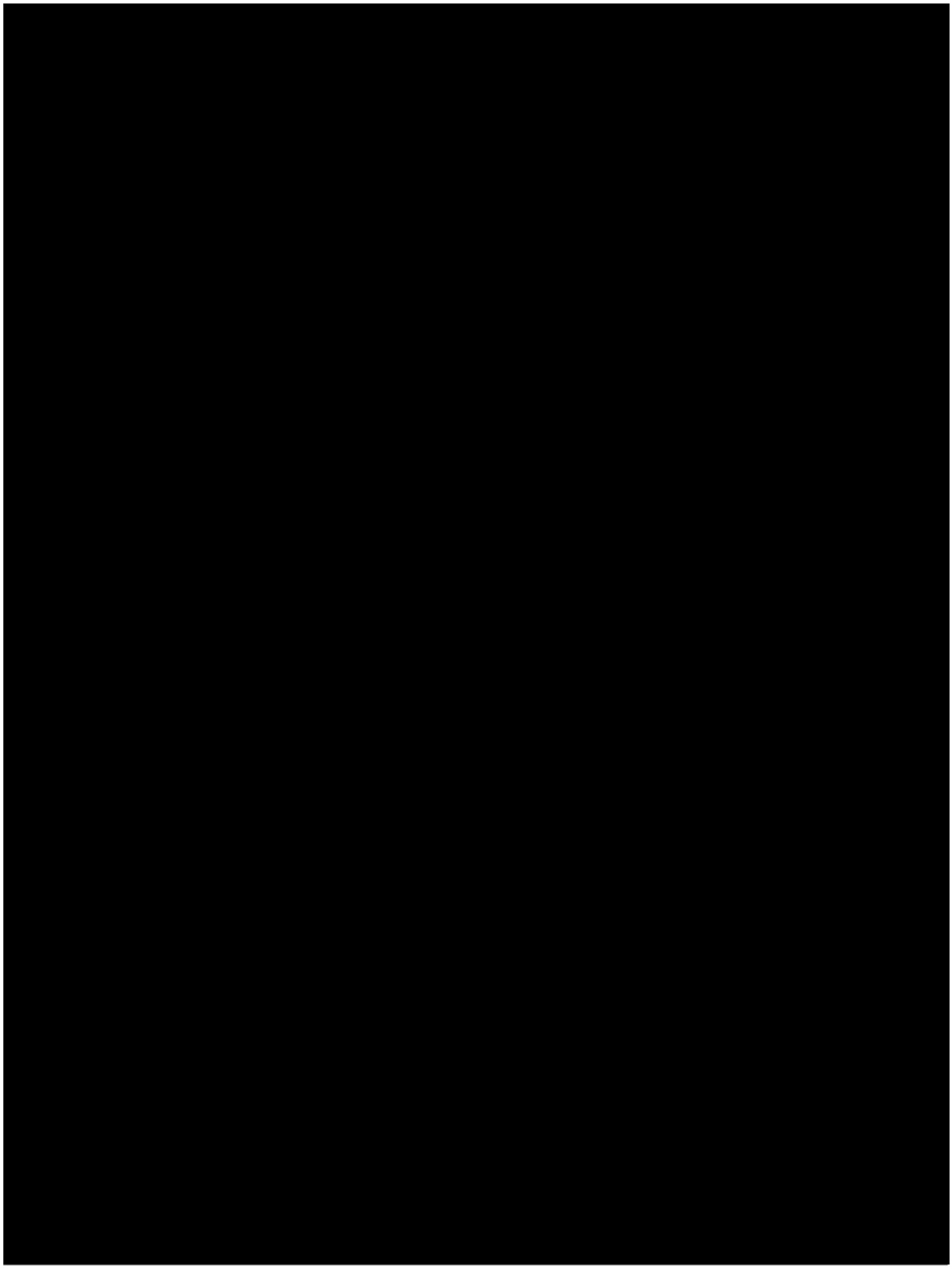
Governmental Orders

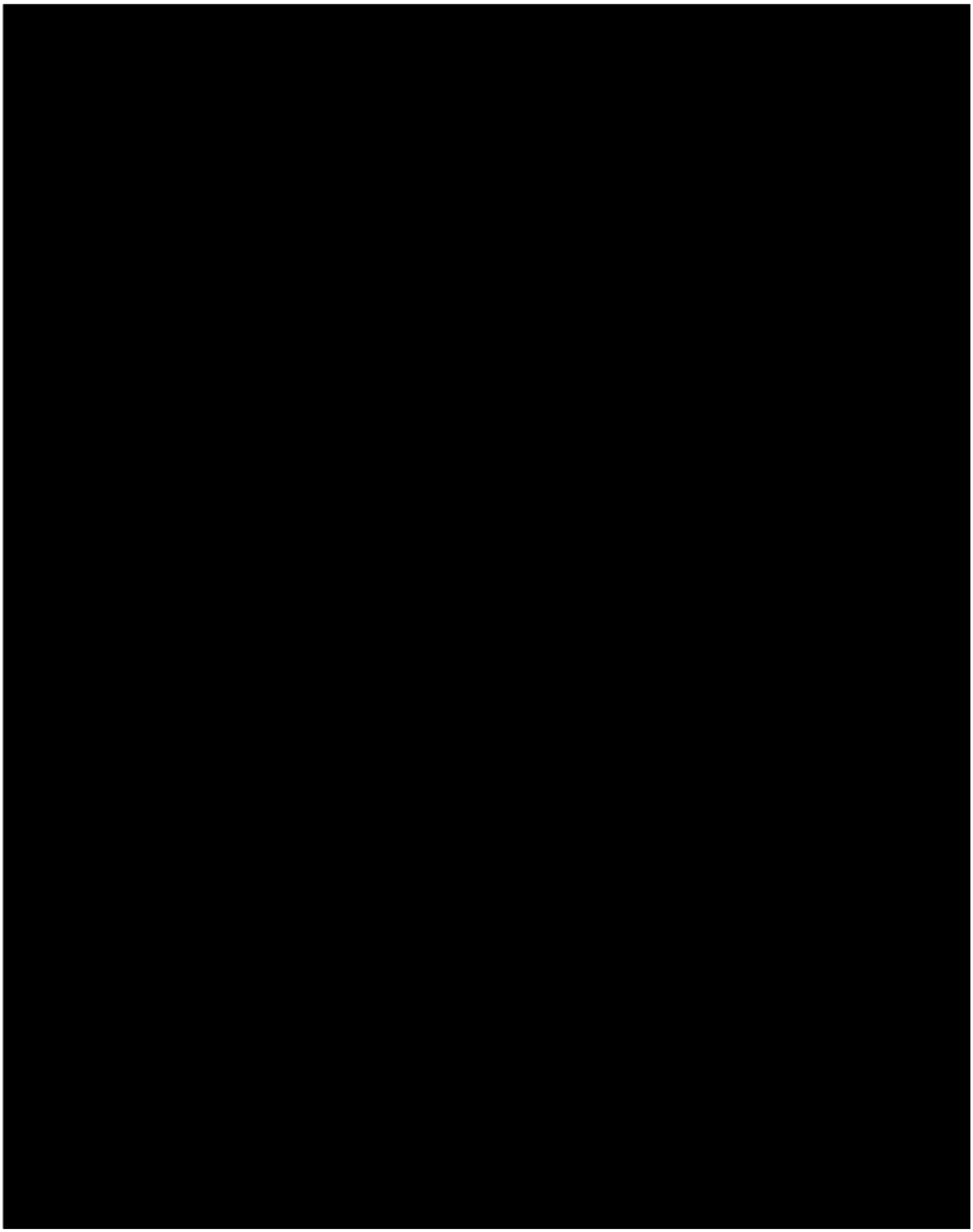
None.

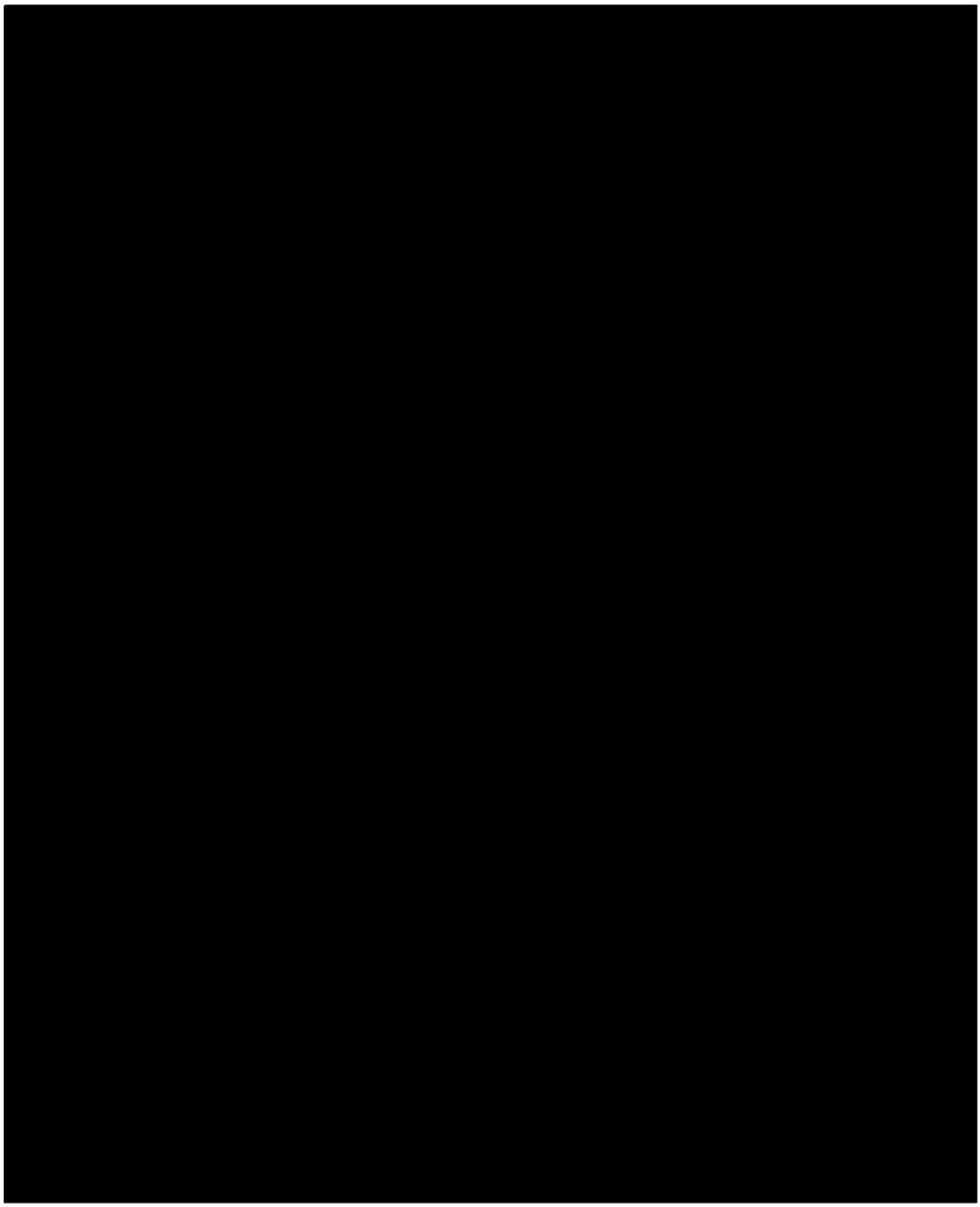
Schedule 6.15(a)

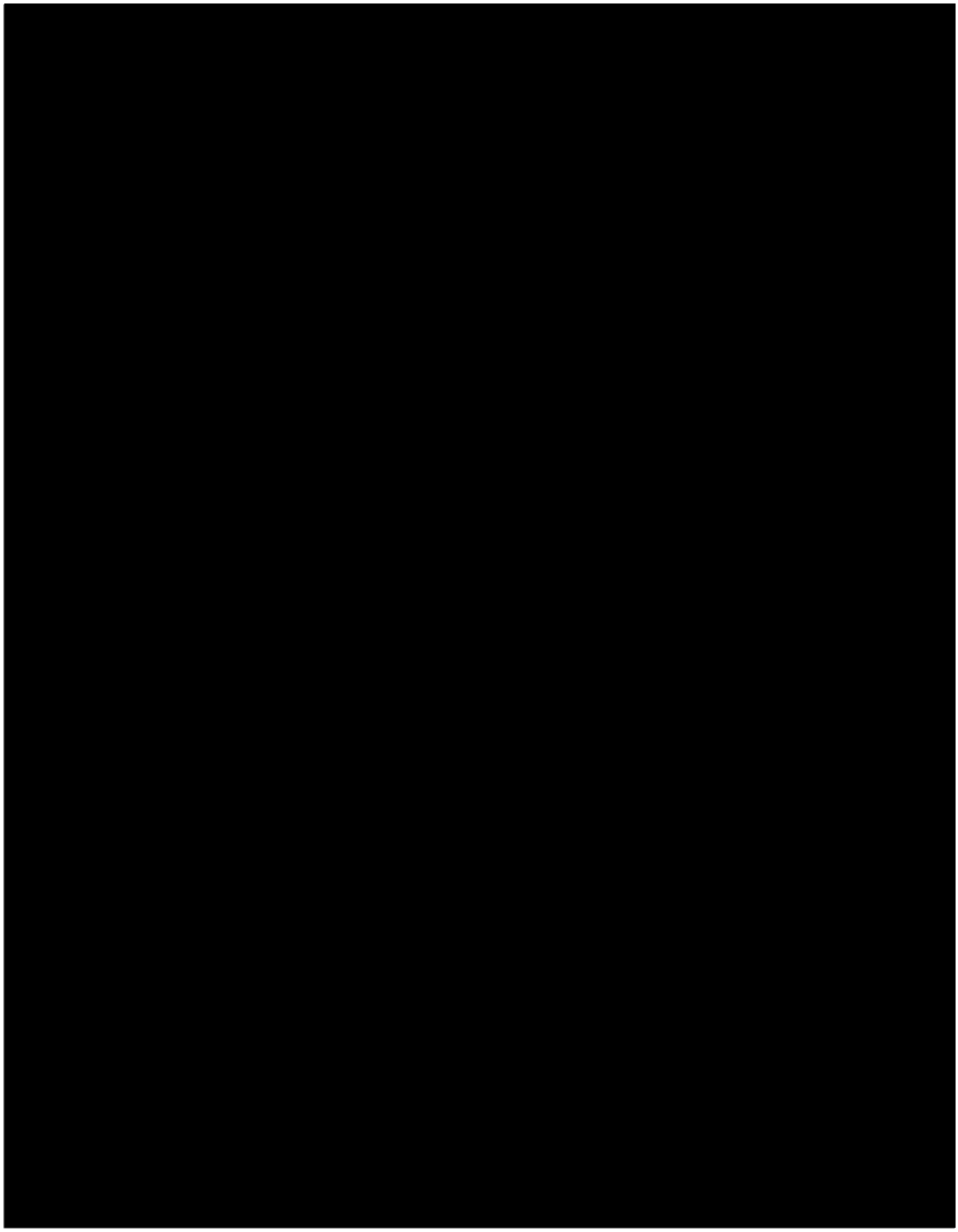
Compliance with Laws

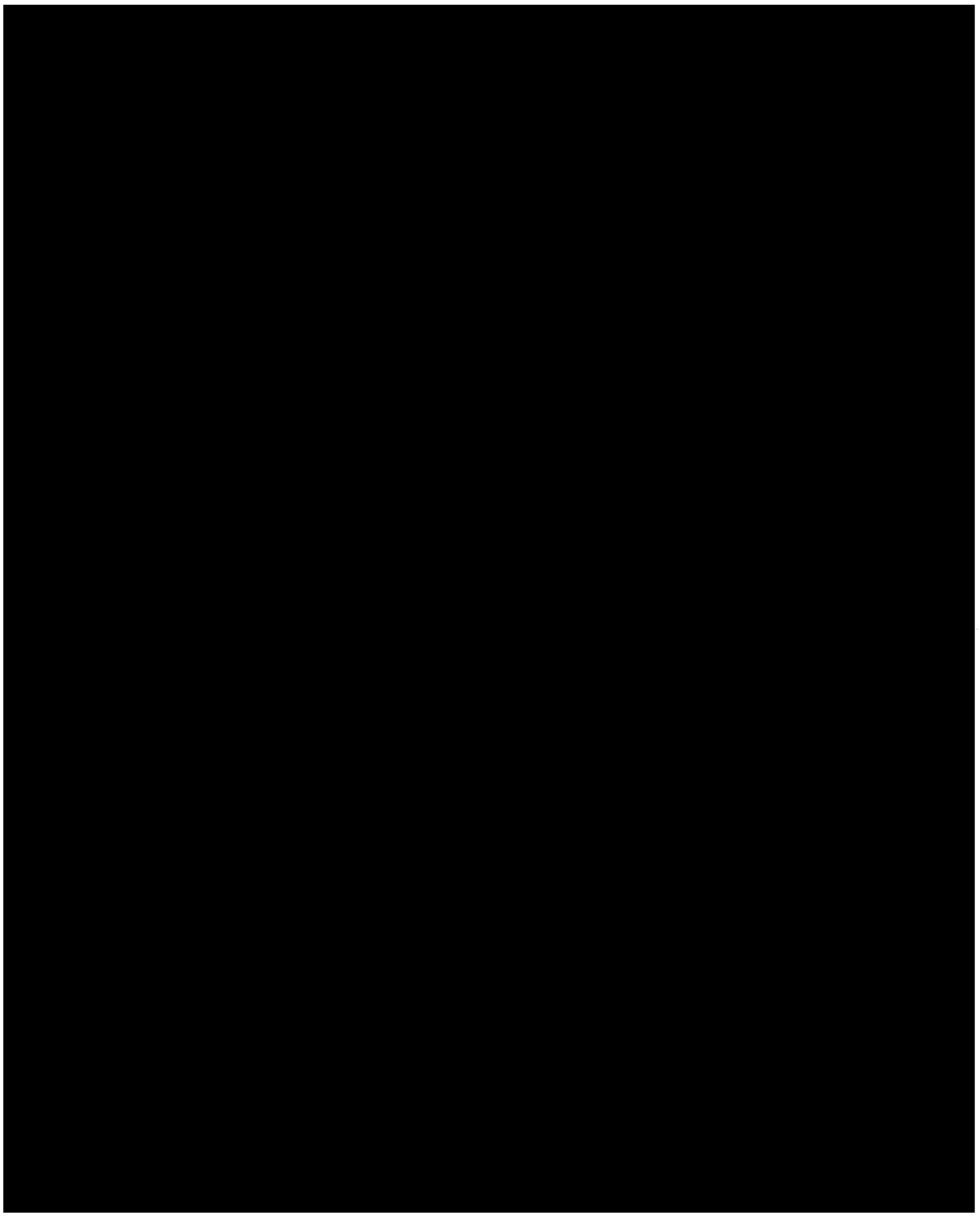
[redacted]

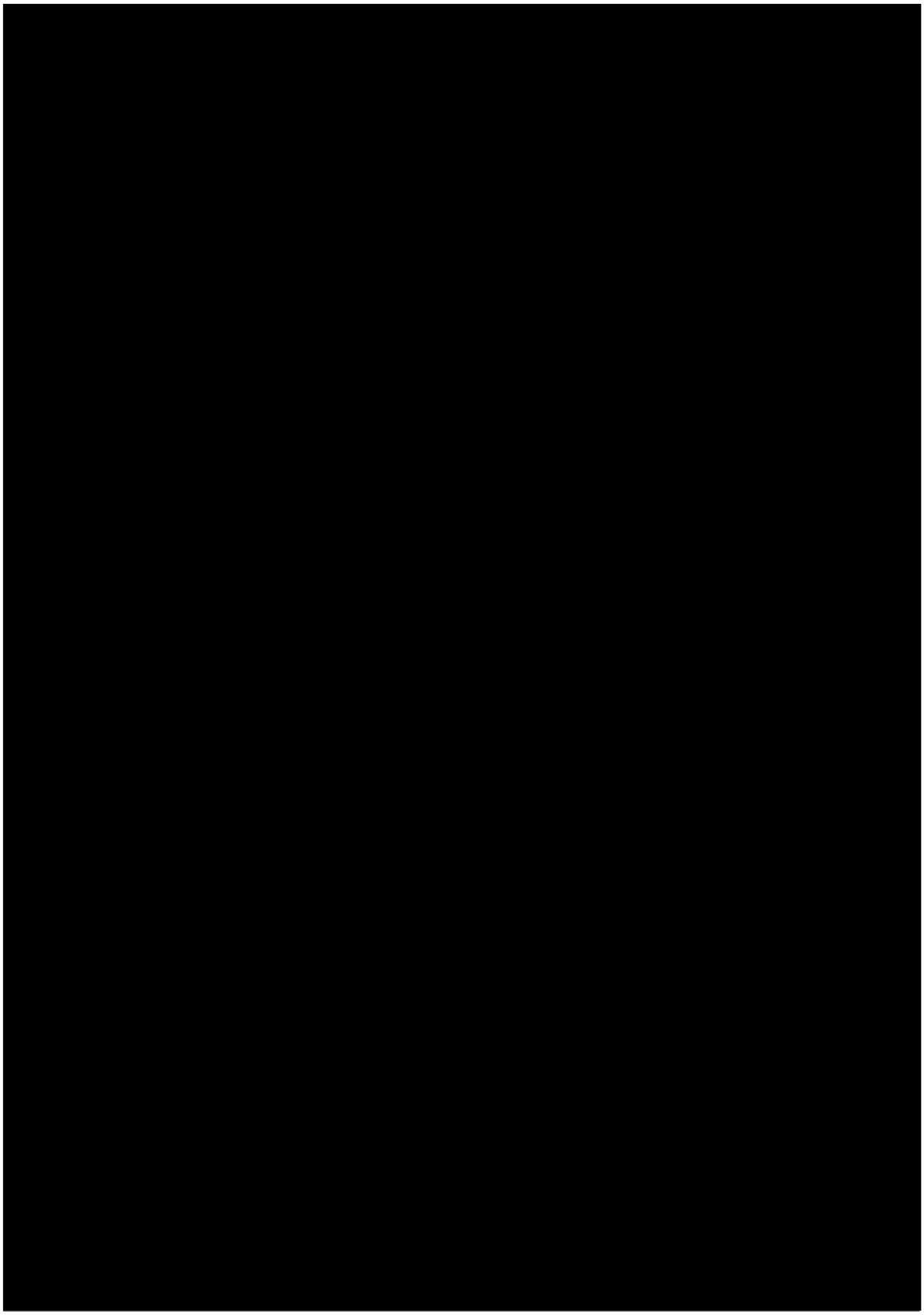


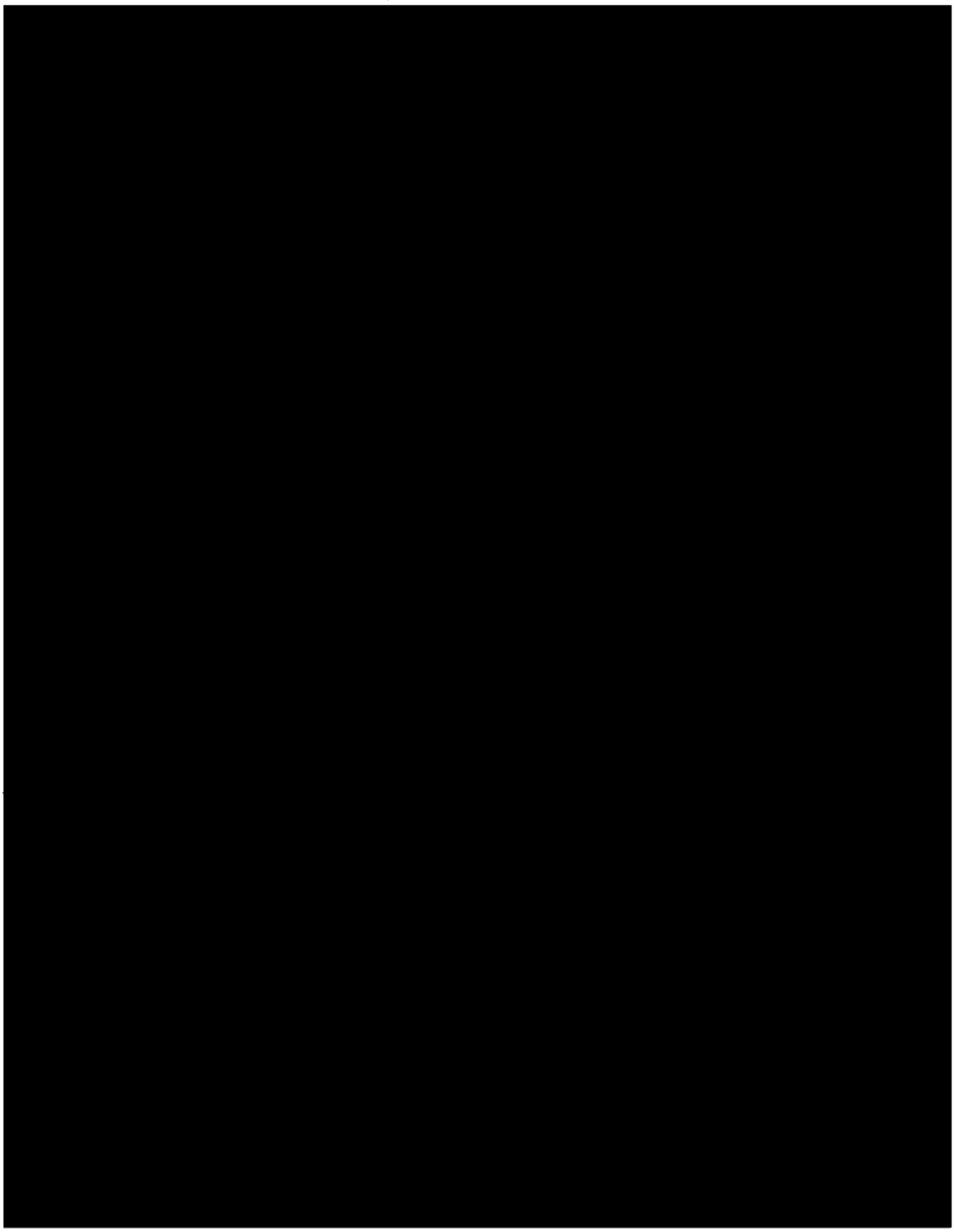












Schedule 6.16(a)

Medicare - Plans of Correction

None.

Schedule 6.16(b)

Medicare - Claims

Other than routine claims for reimbursement before RAC/MAC made in the ordinary course of business and to the knowledge of Saint Mary's, there are no claims, actions, or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures

Schedule 6.16(d)

Medicare - Accreditation Surveys/Deficiency Lists

None.

Schedule 6.19

HIPAA - Breach Notifications

Schedule 6.20

Affiliate Transactions

Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.

1. James C. Smith -Chairman and CEO of Webster Financial Corporation - Saint Mary's is subject to a loan agreement and revolving note with Webster Bank. See Schedule 6.09

2. S. Mark Albini, M.D. - Dr. Albini provides services to Saint Mary's Hospital pursuant to an Administrative Services Agreement, as amended, between Saint Mary's Hospital and Dr. Albini, dated October 1, 2003. Dr. Albini is also subject to an ACO Medical Director Agreement with Saint Mary's Physician Partners, dated December 1, 2014

3. James Uberti, M.D. - Dr. Uberti provides physician services to Franklin Medical Group pursuant to a Physician Employment Agreement, as amended, by and between Dr. Uberti and Franklin Medical Group, dated October 1, 2012

4. Michael Karnasiewicz, M.D. is the president of Neuro Enterprises, LLC which is party to a Neurosurgery Service Line Co-Management Agreement, dated May 1, 2015, by and between Saint Mary's Hospital, Inc., and Neuro Enterprises, LLC

Franklin Medical Group, P.C.

The following physicians sit on the Board of Directors for Franklin Medical Group, P.C. and are also subject to employment agreements with Franklin Medical Group. See **Schedule 6.09.**

1. Rohit Beri, M.D.

2. Laura Brenes, M.D.

3. Philip Corvo, M.D.

4. Jason Ouellette, M.D.

5. Alex Palesty, M.D.

6. Michael Simms, M.D.

7. John Testa, M.D.

8. Steven Schneider, M.D.

9. James Uberti, M.D. - See above

Schedule 6.21(e)

Environmental

1. Underground Storage Tank Closure/Installation Report, dated November 25, 1997, prepared by Coneco Environmental Corporation – CT

2. Fuel Analysis Report, dated January 27, 2011, for 20,000-gallon No. 2 oil tank and 5,000-gallon diesel tank

3. Certified Tank Tightness Inspection Report, dated January 14, 2011, for the 5,000-gallon diesel generator tank

4. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 5,000-gallon diesel generator tank

5. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 20,000-gallon No. 2 fuel oil tank

6. Cathodic Test inspection Report, dated December 3, 2010, for the 20,000-gallon No. 2 Oil Tank and the 5,000-gallon diesel fuel tank

7. Saint Mary's Hospital Asbestos Operations and Maintenance Program, Revision date July 1993

8. Asbestos Building Assessment, dated July 1990, prepared by TRC Environmental Consultants, Inc.

9. Operations and Maintenance Program (for Asbestos-Containing Materials), dated September 1990, prepared by TRC Environmental Consultants, Inc.

10. Letter, dated August 3, 1990, from Asbestos Abatement & Insulation Services, Inc. re: asbestos abatement contract for the Xavier Attic at Saint Mary's Hospital

11. Asbestos Abatement Monitoring and Pre-Renovation Documents for Saint Mary's Elevator Lobby, dated August 19, 2008, prepared by Eagle Environmental

12. Asbestos Removal Specifications for Slocum 4, dated August 7, 1998

13. Asbestos Operations and Maintenance Program, undated

14. Asbestos Disposal and Documentation Form, #22762, dated October 23, 2008

15. Asbestos Disposal and Documentation Form, #99 91358, landfill date November 18, 2005

16. Asbestos Disposal and Documentation Form, #99 63869, landfill date November 18, 2005

17. Final Report for Asbestos Abatement Project, Emergency Room Phase IIA, dated November 29, 2005, prepared by EnviroScience Consultants Inc.

18. Letter from White Insulation, Inc., dated March 10, 2010, enclosing paperwork re: removal and disposal of asbestos containing materials from the Lawlor Building

19. Letter from White Insulation, Inc., dated August 28, 2008, enclosing paperwork re: removal and disposal of asbestos containing materials from the fourth floor of Saint Mary's Hospital

20. Pre-Renovation Hazardous Building Materials Inspection of Saint Mary's Existing Main Entrance Lobby, dated June 27, 2007, prepared by Eagle Environmental, Inc.

21. Bulk Sample Collection and Analysis of Central Supply Decontamination Room, dated December 13, 2007, prepared by Eagle Environmental, Inc.

22. Bulk Sample Collection and Analysis of Saint Mary's Front Entrance, dated May 16, 2007, prepared by Eagle Environmental, Inc.

23. Hazardous Building Materials Inspection, Abatement Design and Monitoring Services of Saint Mary's Existing Main Entrance Lobby, dated May 16, 2007, prepared by Eagle Environmental, Inc.

24. Proposal from Eagle Environmental, Inc., dated January 25, 2008, re: Asbestos Containing Materials Re-occupancy Services

25. Bulk Sample Collection and Analysis of Kenny Building-2nd Floor Operating Room, dated January 11, 2008, prepared by Eagle Environmental, Inc.

26. Limited Asbestos Inspection Report, dated June 4, 2010, prepared by Superior Industries LLC

27. Letter from White Insulation, Inc., dated August 28, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

28. Asbestos Analysis of Bulk Materials in the Kenny Building and Conference Center 5th Floor, dated February 10, 2010, prepared by Superior Industries L.L.C.

29. Letter from White Insulation, Inc., dated July 17, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

30. Letter from White Insulation, Inc., dated October 19, 2006, enclosing a copy of a waste manifest for asbestos containing materials removed from Saint Mary's Hospital

31. Letter from White Insulation, Inc., received by Saint Mary's on June 27, 2007, enclosing paperwork re: removal and disposal of asbestos containing materials from Saint Mary's

32. Letter from ChemScope, dated May 27, 1994, re: bulk asbestos samples from Saint Mary's Hospital

33. Asbestos Pre-Renovation Inspection for O'Brien Roof Renovation, dated June 4, 2004, prepared by ChemScope

34. Asbestos Removal Monitoring for O'Brien Building for May 29, 1997 to July 11, 1997, prepared by ChemScope

35. Bulk Sample Collection and Analysis of Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

36. Letter from Superior Industries, L.L.C., dated December 15, 2010, re: asbestos testing in Xavier Room 232A area

37. Letter from White Insulation, Inc., dated October 23, 2007, enclosing waste manifest for asbestos containing materials abated at Saint Mary's

38. Asbestos Analysis of Bulk Materials in Xavier, dated January 8, 2011, prepared by Superior Industries L.L.C.

39. Letter from Eagle Environmental, Inc., dated September 6, 2007, re: proposal to provide a pre-renovation asbestos containing materials

40. Asbestos Removal Manual for Saint Mary's Foyer Renovation, prepared by Eagle Environmental, Inc.

41. Letter from Eagle Environmental, Inc., dated August 1, 2007, re: proposal to provide asbestos abatement services for the renovation of the Main entrance lobby

42. Bulk Sample Collection and Analysis for Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

43. Asbestos Disposal and Documentation Form, #142365, landfill date August 11, 2008

44. Asbestos Disposal and Documentation Form, #142366, landfill date August 11, 2008

45. Asbestos Disposal and Documentation Form, #142354, landfill date August 11, 2008

46. Uniform Hazardous Waste Manifest, # 002053366, landfill date September 15, 2008

47. Letter from ChemScope, dated July 30, 1993, enclosing copy of Asbestos O&M Program

48. Restatement of Policy Requirements for handling the spray on fireproofing found in the ceiling spaces of the O'Brien Building, floors 6, 7, and 8, dated April 16, 1991, prepared by TRC Environmental Consultants, Inc.

49. Report from TRC, dated January 21, 1986, re: asbestos project work conducted at Saint Mary's in January 1986

50. Letter from ChemScope, dated December 4, 1991, re: results from bulk samples

51. Letter from ChemScope, dated September 10, 1993, re: results from bulk samples

52. Letter from ChemScope, dated June 13, 1991, enclosing copies of final clearance testing after asbestos abatement for O'Brien 6, 7, and 8 elevator

53. Asbestos Abatement Specifications/Invitation to Bid, prepared by ChemScope Inc., dated March 4, 1991

54. ACM Monitoring Main Entrance Lobby Renovation Project, dated December 20, 2007, prepared by Eagle Environmental, Inc.

55. Bulk Sampling/Analysis Record for Boiler House – New D.A. Tank Room, dated November 20 (year unclear – possibly 1992)

56. Asbestos Abatement Report for MOB Elevator Lobby and CAT Scan, dated December 17, 1993, prepared by AEGIS Inc.

57. Report, dated August 4, 1994, prepared by ChemScope re: Asbestos Removal Monitoring of O'Brien 6-Mechanical Rooms and Adjacent Office Asbestos Removal Monitoring from June 13, 1994 through July 30, 1994

58. Asbestos Removal Specifications for O'Brien 6, dated May 2, 1994

59. Asbestos Abatement Report for Xavier Basement Mechanical room, dated March 24, 1994, prepared by AEGIS Inc.

60. Asbestos Abatement Project Site Monitoring Report for December 18, 1995 through February 8, 1996 for O'Brien 7, prepared by Mystic Air Quality Consultants, Inc.

61. Final Documentation Package for Asbestos Removal in MOB Elevator Lobby and CAT Scan, dated January 7, 1994, prepared by Haz-Pros, Inc.

62. Letter from AAIS, dated February 16, 1994, enclosing disposal documentation for various asbestos abatement and removal projects at Saint Mary's Hospital

63. Asbestos Removal Specifications for Xavier Attics, dated July 25, 1990

64. Certificate of Completion and Disposal Documentation Form for Abatement of Nun's Dining Room, dated October 1990

65. Letter from Acstar Insurance Company, dated July 10, 1991, re: status of bond concerning the Xavier and Slocum Basements

66. AAIS Certification of Payment of all Debts and Claims concerning Slocum and Xavier Basements, dated June 26, 1991

67. Letter from TRC, dated August 15, 1990, re: Justification for Alternative Work Practices

68. Letter from TRC, dated November 6, 1990, re: Completion of Asbestos Abatement of Slocum and Xavier Crawlspaces

69. AAIS Certification of Completion of abatement of crawl spaced, received October 26, 1990, enclosing copy of the Asbestos Abatement Project Notification Form and Asbestos Disposal and Documentation Form

70. Report on Fibrous Dust in Air Analysis, dated October 16, 1990, prepared by Environmental Hazard Control Associates, Inc.

71. Performance Bond, dated September 20, 1990, issued by the American Institute of Architects to AAIS in the amount of $38,500.00

72. Documentation of Approved Disposal of Asbestos Waste, dated September 1990 and October 1990

73. Asbestos Abatement Project Notification Form for work to be completed by September 5, 1990 (may be duplicate of Xavier Attic)

74. Asbestos Removal Specifications for Saint Mary's Penthouse, dated August 7, 1990, prepared by ChemScope

75. Final Inspection of Asbestos Clean-up Action, dated June 20, 1989, prepared by Statewide Environmental Services re: clean-up of electrical box

76. Approval for Special Waste Disposal – Asbestos, dated September 30, 1987, issued by the CTDEP

77. Letter from Saint Mary's, dated January 15, 1988, re: asbestos removal at Saint Mary's Hospital

78. Letter from Marsh &McLennan, dated January 26, 1988, re: asbestos removal at Saint Mary's Hospital

79. Letter from Manville Property Damage Settlement Trust, dated August 7 1989, re: filing first-cycle claims

80. Letter from Saint Mary's, dated July 20, 1987, re: scope of asbestos removal in boiler room and adjacent areas

81. Letter from Sitewide Environmental Services, dated May 19, 1988, re: disposal of asbestos from Saint Mary's at S&S Landfill in Clarkburg, West Virginia

82. Saint Mary's internal memorandum, dated March 29, 1988, re: amount of liability insurance for asbestos removal project

83. Saint Mary's internal memorandum, dated January 25, 1989, re: asbestos removal from the gift shop

84. Asbestos Removal Documentation for removal of 40 linear feet of asbestos pipe covering in March/April 1989

85. Non-hazardous Special Waste Manifests, dated November 19, 1990

86. Invoice from Ever Clear, dated April 30, 1990, re: removal of 135 feet of pipe covering

87. Asbestos removal documentation from Ever Clear re: removal of asbestos from valves and tees in mechanical room

88. Asbestos Fiber Analysis by Transmission Electron Microscopy, Selective Area Electron Diffraction and Energy Dispersive X-Ray Microanalysis, dated August 11, 1990, prepared by EMSL

89. Asbestos Preventative Maintenance Record, dated June 23, 1989, re: asbestos removal from pipe located in Xavier Attic for 3 inch steam line repair

90. Asbestos Preventative Maintenance Record, dated September 1, 1987, to change pressure regulating valve on heating system

91. Asbestos Preventive Maintenance Record, dated March 3, 1987, to remove make up water pump

92. Asbestos Preventive Maintenance Record, dated January 29, 1987, to make repairs to HAVAC unit

93. Asbestos Preventive Maintenance Record dated January 9, 1987, re: accidentally disturbed asbestos while making plumbing repair over top of boiler

94. Asbestos Preventive Maintenance Record, dated June 11, 1986, re: high pressure steam line leaking

95. Asbestos Preventive Maintenance Record, dated June 9, 1986, re: steam leak

96. Saint Mary's Interoffice Memorandum, dated January 13, 1986, re: removal of four barrels of asbestos

97. Approval for Special Waste Disposal Asbestos, dated May 13, 1985, issued CTDEP

98. Asbestos Preventive Maintenance Record, dated August 7, 1985, re: removal of duct to incinerator double plastic

99. Asbestos Preventive Maintenance Record, dated July 29, 1985, re: future removal of incinerator in School of Nursing

100. Asbestos Preventive Maintenance Record, dated March 9, 1985, re: removed asbestos because it was loose

101. Asbestos Preventive Maintenance Record, dated January 17, 1985, re: notification by manufacture and insulation replacement provided by Air Shield

102. Asbestos Preventive Maintenance Record, dated September 11 and 12, 1984, re: facilitate removal of head from heat exchanger in OB-SB

103. Asbestos Preventive Maintenance Record, dated January 25, 1984, re: remove pipe insulation to disconnect chill water coil

104. Asbestos Preventive Maintenance Record, dated January 2, 1984, re: water leak in SA city water bypass

105. Asbestos Preventive Maintenance Record, dated December 20, 1983, re: removal of asbestos from piping on hot water heater

106. Charge ticket from City of Waterbury – Solid and Liquid Waste Disposal, dated October 23, 1985

107. Approval for Special Waste Disposal – Asbestos, dated May 11, 1987, issued by the CTDEP

108. Saint Mary's Policy re: A.C.M. Asbestos Containing Material, dated December 30, 1985

109. Saint Mary's Interoffice Memorandum, dated June 20, 1983, re: asbestos removal on June 16, 1983

110. Saint Mary's Engineering Policy and Procedure Manual, dated December 6, 1983, re: Removal of Asbestos Insulation

111. Saint Mary's Interoffice Memorandum, dated April 21, 1980, re: Asbestos Fiber Containment

112. Saint Mary's internal memorandum, dated April 4, 1985, re: asbestos tests

113. Asbestos Removal Monitoring invoices, contracts, specifications, laboratory results, pre-abatement inspections and project summaries for the Courtyard Roof and Dietary Mechanical Room, dated December 1992 – February 1993

114. Ambient Air Asbestos Testing, Asbestos Project Summaries, Air Samples, Asbestos Worker Certifications, dated January 1992 – March 1992 and CTDPH Application for Approval of Alternative Work Practice, dated December 26, 1991

115. Asbestos Removal Monitoring for the Boiler Room Office, DA Tank Room and O'Brien 4 Mechanical Room, dated February 1, 1993 – February 4, 1993

116. Asbestos Disposal & Documentation Form, dated August 27, 1993

117. Asbestos Disposal & Documentation Form, dated August 11, 1993

118. Asbestos Abatement Report, MRI Hall, KB49 and KB50 prepared by Aegis, Inc. Environmental Consultants, dated November 4, 1993

119. Asbestos Disposal & Documentation Form, dated November 8, 1993

120. AEGIS Analytical Report, dated November 1993

121. Logano Asbestos Disposal & Documentation Form, dated November 8, 1993

122. AAIS Certificate of Completion, dated August 25, 1993, for asbestos removal on 1st & 2nd Floors of O'Brien Wing

123. AAIS Proposed Scope of Work letter, dated May 18, 1993, for the elevator lobby on 5th floor

124. AAIS Certificate of Completion and related documentation for Kinney X-Ray 4 & 5, dated November 1, 2004

125. ChemScope Asbestos Pre-Renovation Inspection for Kenny 1 Radiology Hallways Floor Tile, dated November 19, 2004

126. ChemScope Bulk Sample Identification and Findings, dated July 10, 1996

127. ChemScope Asbestos Abatement Specifications for O'Brien 8 (no drawings included), dated October 28, 1996

128. ChemScope Asbestos Removal Specifications for O'Brien 8, dated October 28, 1996

129. ChemScope Asbestos Removal Specifications for O'Brien 8, dated July 24, 1997

130. ChemScope Bulk Sample Identification and Findings, dated March 6, 1992

131. ChemScope Monitoring and Air Sampling for Mammography and Elevators 9 and 10, dated March 16, 1992 – March 17, 1992

132. ChemScope Monitoring and Air Sampling for ER Radiology Sections I & II, dated April 20, 1992 – April 21, 1992

133. AAIS Certificate of Completion for Asbestos Removal at the 3rd Floor Garage Elevator / Sections I & II Lobby, dated August 1992

134. ChemScope Bulk Sample Identification and Findings, dated November 23, 1992

135. Saint Mary's Bulk Sampling / Analysis Record Results for Boiler House – New D.A. Tank Room, dated November 13, 1992

136. AEGIS Air Monitoring Report, dated February 5, 1993

137. ChemScope Bulk Sample Identification and Findings, dated January 13, 1992

138. ChemScope Bulk Sampling / Analysis Record for O'Brien 5, dated January 13, 1992

139. CT Department of Health Services Asbestos Abatement Notification Form, dated July 22, 1991

140. Logano Asbestos Disposal & Documentation form, dated March 20, 1992

141. Logano Asbestos Disposal & Documentation forms, dated March 5, 1992

142. AAIS Certificate of Completion for Asbestos Removal at O'Brien Cafeteria Entrance, O'Brien Basement and O'Brien Subbasement Connector, dated March 30, 1992

143. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

144. ChemScope Air Sampling Results for 3rd Floor Garage Elevator Area Sections I and II, dated July 11, 1992

145. AEGIS Analytical Reports, dated March 5, 1992

146. ChemScope Bulk Sample Identification and Findings, dated July 28, 1992

147. Asbestos Abatement Specifications for the O'Brien Laboratory Department, 2nd Floor, dated November 8, 1991

148. ChemScope Bulk Sample Identification and Findings, dated November 25, 1991

149. TRC Request for Confirmation regarding asbestos work in the Basement and 5th Floor, dated January 29, 1991

150. ChemScope Ambient Asbestos Air Samples, dated July 23, 1990

151. TRC Asbestos Building Assessment, dated July 1990

152. TRC Summary Report – Quarterly Air Monitoring, dated June 1991

153. TRC Summary Report – Asbestos Removal Activities, dated December 1990

154. TRC Summary Report – Quarterly Air Monitoring, dated January 1991

155. AEGIS Report of Ambient Air Sampling, dated December 10, 1991

156. ChemScope Asbestos Sample Identification, dated October 31, 1991

157. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

158. Various Basement Sampling Results, dated December 27, 1991

159. ChemScope Bulk Sample Identification and Findings, dated May 28, 1991

160. ChemScope Bulk Sample Identification and Findings, dated April 1991

161. EnviroMed Laboratory Analysis Reports, dated April 1991

162. Declaration of Fran Fahy that there is asbestos in the ceiling of Radiation Therapy, dated September 11, 1990

163. Ever Clear Final Sample Test Report, dated May 31, 1990

164. ChemScope Post Abatement Asbestos Air Samples, dated August 31, 1990

165. ChemScope Asbestos Removal Monitoring for the Boiler Room, dated August 23, 1990

166. ChemScope Ambient Air Samples from Boiler Room, dated July 23, 1990

167. ChemScope Asbestos Air Samples, dated April and May 1988

168. Statewide Environmental Services Air Sampling for Friable Asbestos, dated October 3, 1988

169. ChemScope Asbestos Removal Monitoring for Xavier Attics North/South, dated September 1, 1990

170. Saint Mary's Memorandum regarding TRC Air Samples, dated August 7, 1990

171. TRC Verification of Sample Analysis for debris in the Boiler Room, dated July 25, 1990

172. TRC Physician's Notification of Requirement of Physical Examinations, dated April 16, 1991

173. TRC Completion of Asbestos Removal and Cleanup for the Boiler Room and Xavier North/South Attics, dated September 14, 1990

174. TRC letter regarding properly managing asbestos and the Hospital's liability, dated July 30, 1990

175. TRC handwritten letter regarding the floor locations to be inspected as part of the Asbestos Management Program, dated August 10, 1990

176. ChemScope Asbestos Removal Specifications for the Kenny Basement, dated May 29, 1997

177. ChemScope Asbestos Removal Specifications OB SB-1, Mechanical Room, K1 Radiology Rooms 1 & 2, Dark Room, Slocum Pipe Chase Levels B thru 4 and SH Condensate Pump Room, dated January 30, 1997

178. Asbestos Removal and Area Decontamination – Supplementary General Conditions (starts with Table of Contents)

179. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 8, 1997 through July 9, 1997, dated July 23, 1997

180. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 10, 1997 through July 16, 1997, dated July 23, 1997

181. ChemScope Final Clearance Testing After Asbestos Abatement, dated July 21, 1997

182. ChemScope Asbestos Bulk Sampling for O'Brien 6 Penthouse (mud on exposed ends of fiberglass insulated lines adjacent to heating and chilled water pumps), dated November 13, 2001

183. ChemScope Asbestos Bulk Sampling for O'Brien 5 PT Gym Room Floor Tile and Mastic, dated November 29, 2001

184. Certificate of Completion and related documents for O'Brien 1st Floor, dated April 4, 2001

185. Certificate of Completion and related documents for Kenny Basement Stairwell Tile, dated October 11, 2000

186. Certificate of Completion and related documents for Pick Up & Disposal, dated August 10, 2000

187. ChemScope Asbestos Pre-Renovation Inspection for O'Brien 1 – Inpatient Mental Health – Hellman Pavilion, dated February 11, 1999

188. Asbestos Air Monitoring, dated February 22-23, 1999, prepared by Dale Environmental, Inc.

189. ChemScope Bulk Sampling / Analysis Record for O'Brien - Inpatient Mental Health – Hellman Pavilion, dated February 1999

190. Asbestos Inspection, dated February 3, 1999, prepared by Dale Environmental, Inc.

191. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #5, dated July 16, 1999

192. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #4, dated July 16, 1999

193. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #1, dated July 16, 1999

194. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #3, dated July 16, 1999

195. Asbestos Abatement Specification for Cardiac Cath Lab, 2nd Floor, Sacred Heart Building, dated February 1999, prepared by Dale Environmental, Inc.

196. ChemScope Asbestos Pre-Renovation Inspection for Xavier 1 Auxiliary Office Area, dated February 12, 1998

197. ChemScope Asbestos Removal Monitoring for February 21, 1997 through March 8, 1997, dated March 31, 1997

198. Internal Memorandum regarding the Status of the Manville Property Damage Settlement Trust and related documents including claim payment information, dated 1996-1997

199. ChemScope Bulk Sample Identification and Findings (submitted as evidence for the Manville Property Damage Settlement), dated July 27, 1991 – May 13, 1995

200. AEGIS Certificate of Visual Inspection, dated March 23, 1994

201. Notification to the EPA of Demolition and Renovation Activities for MRI-KB, dated October 1, 1993

202. List of Asbestos Removal Areas/Costs from 1987 to Present, dated February 26, 1991

203. List of Asbestos Monitoring Areas/Costs from July 1990 to Present, dated February 26, 1991

204. AAIS Certificate of Completion of Asbestos Removal at Saint Mary's Hospital O'Brien Elevator Project and related Asbestos Disposal & Documentation Forms and Asbestos Abatement Notification Form

205. Letter from ChemScope, dated April 17, 1989, re: Asbestos Identification in Samples

206. Letter from TRC, dated November 30, 1990, re: Draft Scope of Asbestos Work

207. Letter from TRC, dated October 3, 1990, re: Saint Mary's Hospital Asbestos Management Program

208. Letter from Cannon, dated August 14, 1990, re: vinyl asbestos tile in the Kenny Pavilion

209. Letter from TRC, dated August 10, 1990, re: Inspections of Parking Garage and Convent Building

210. Letter from ChemScope, dated July 22, 1990, re: Air Monitoring at Saint Mary's Hospital Boiler Room Asbestos Removal, Pipe Residuals

211. Letter from TRC, dated December 18, 1990, re: completion of removal of vinyl asbestos floor tile from the old vending machine room

212. ChemScope Certificate of Analysis, dated February 17, 1998, re: bulk samples collected on February 12, 1998

213. Asbestos Disposal and Documentation Form, dated January 21, 1997

214. Asbestos Disposal and Documentation Form, dated September 6, 1996

215. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Marley Tower in September 1991

216. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Quality Assurance Office Area 2 in July 1991

217. AAIS Certificate of Completion, dated November 23, 1993, re: asbestos removal at MRI KB-49 and KB-50

218. Letter, dated August 6, 1990, from TRC Environmental Consultants, Inc. re: Transmission Electron Microscope Analysis of Air Samples

219. Asbestos Disposal & Documentation Form for the Xavier Attic

220. Asbestos Abatement Project Notification Form for the Xavier Attic

221. Asbestos Project Summary and Asbestos Preabatement Inspection, prepared by ChemScope, for the Xavier Attic

222. ChemScope Asbestos Pre-Renovation Inspection for Roof Renovation – O'Brien 8 Roof, dated June 2004

223. American Hospital Association letter regarding Claim Forms for Filing Claims with the Manville Property Damage Settlement Trust, dated May 1985

224. Specifications for Procedures to Prevent Asbestos Contamination and Exposure During Containment Construction for Asbestos Abatement Work, dated August 1990

225. NHD Waste Shipment Record, dated July 16, 1997

226. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #2, dated July 16, 1999

227. Notification of Regulated Waste Activity, dated January 12, 2000

228. Saint Mary's Hospital Hazardous Materials Management Program, dated March 5, 2009; Revised March 6, 2009

229. 2009 Biennial Hazardous Waste Report for Saint Mary's Hospital, submitted by GZA GeoEnvironmental, Inc. on February 26, 2010

230. Budgetary Quotation, dated February 25, 2010, from United Industrial Services to Saint Mary's Hospital

231. Course Outline for Saint Mary's Hospital Hazardous Waste Training RCRA-OSHA-DOT Sessions 1, 2, and 3

232. List of Hazardous Material and Waste Storage Areas

233. Tier II Emergency and Hazardous Chemical Inventory Form Certification for Reporting Year 2009

234. Anesthetic Waste Gas Monitoring Report, dated November 2, 2009, prepared by Praxair

235. Anesthetic Waste Gas Monitoring Report, dated May 1, 2009, prepared by Praxair

236. Ethylene Oxide Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

237. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2007

238. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2006

239. Compliance Indicator Survey Information Sheet/Hazardous Waste Partial Compliance Evaluation for Saint Mary's Hospital, dated June 27, 2006

240. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2005

241. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2003

242. CT DEP Permit to Operate a Caterpillar D-349 Diesel Generator, No. 192-0093

243. CT DEP Permit to Construct and Operate a Caterpillar Model 3508TA diesel standby generator, No. 192-0116

244. Saint Mary's Compliance Plan for Connecticut Regulations for the Control of Oxides of Nitrogen, dated August 1994

245. Pre-Inspection Questionnaire (PIQ) for Calendar Year 1999

246. Pre-Inspection Questionnaire Report for Inspection Date June 28, 2000

247. Notice of CT DEP Air Inspection, dated March 26, 2004

248. Pre-Inspection Questionnaire (PIQ) for Calendar Year 2003

249. Letter, dated May 7, 2010, from GZA to Saint Mary's Hospital Re: Results of Greenhouse Gas Emissions Evaluation

250. Registration/Application to Seek Coverage Under the General Permit to Limit Potential to Emit for Saint Mary's Hospital, dated March 2006

251. Approval of Registration for General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, Effective Date June 15, 2006

252. CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, issued November 19, 2010

253. 2009 Annual Compliance Certification Form for CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution

254. Letter from GZA, dated January 20, 2011, re: 2010 GPLPE Annual Compliance Certification

255. Letter from CTDEP, dated January 8, 2008, re: notice of plant inspection on March 12, 2008

256. Indoor Air Quality Survey, dated May 6, 2009, for Lawlor Building

257. Environmental Testing at Saint Mary's Hospital re: Air Change Rates/Indoor Air Quality, dated February 2007, prepared by Praxair

258. Formaldehyde Vapor Analysis Reports, dated April 16, 2008, prepared by Praxair

259. Air Change Rate Report, dated May 1, 2009, prepared by Praxair

260. Acetic Acid & Hydrogen Peroxide lab Results Report, monitoring date May 26, 2009, prepared by Praxair

261. Fume Hood Environmental Monitoring Report, dated March 22, 2006, prepared by Praxair

262. Environmental Monitoring at Saint Mary's Hospital re: Air Change Rates, Indoor Air Quality, and Microbiological/Mold, dated March 2008, prepared by Praxair

263. Environmental Monitoring for Saint Mary's Child Development Center re: Air Change Rates and Indoor Air Quality, dated November 2007, prepared by Praxair

264. Environmental Monitoring for Saint Mary's Hospital re: Air Change Rates and Indoor Air Quality, dated January and February 2008, prepared by Praxair

265. Fume Hood Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

266. Fume Hood Environmental Monitoring Report, dated November 2, 2009, prepared by Praxair

267. Air Change Rate Report, dated November 2, 2009, prepared by Praxair

268. Air Change Rate Report, dated March 22, 2006, prepared by Praxair

269. Environmental Monitoring Report for Fume Hood, dated June 2010, prepared by Praxair

270. 2008 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

271. 2006 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

272. Boiler Operating Certificates 1995-2010

273. State of Connecticut DEP-Air Management Bureau-Hartford Premise Evaluation Report for inspection date April 26, 2004

274. 2005 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

275. 2004 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

276. 2003 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

277. 2002 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

278. 2001 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

279. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 2000

280. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1999

281. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1998

282. Letter from the City of Waterbury, dated January 23, 2001, re: cross connection inspection

283. Letter from the City of Waterbury, dated January 18, 2001, re: test results from November 28, 2000 backflow prevention test

284. Letter from the City of Waterbury, dated January 5, 2000, re: test results from November 29, 1999 backflow prevention test

285. Letter from the City of Waterbury, dated June 22, 1998, re: test results from May 19, 1998 backflow prevention test

286. Letter from the City of Waterbury, dated January 7, 1998, re: test results from the reduced pressure backflow preventer testing on November 26 and 28, 1997

287. Letter from the City of Waterbury, dated March 26, 1997, re: test report from backflow prevention testing on March 26, 1997

288. Letter from the City of Waterbury, dated January 14, 1997, re: test results from November 29, 1996 backflow prevention test

289. Letter from the City of Waterbury, dated January 22, 1996, re: test results from November 24 and 26, 1995 backflow prevention tests

290. Letter from the City of Waterbury, dated January 22, 1996, re: violations detected during November 26, 1995 backflow prevention test

291. Letter from the City of Waterbury, dated January 31, 1996, re: compliance confirmed during reinspection conducted on November 24 and 25, 1995

292. Registration Form for Reauthorization Under the Domestic Sewage General Permit

293. Minor Photographic Processing General Permit for the Hospital (Certificate of Registration; General Permit Application No. 200700007; and Certification Form GPH2)

294. Minor Photographic Processing General Permit for the Dental Clinic (Certificate of Registration; General Permit Application No. 200700005; and Certification Form GPH2)

295. Minor Photographic Processing General Permit for the Naugatuck Walk-in Center (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700008; and Certification Form GPH2)

296. Minor Photographic Processing General Permit for Franklin Surgical Site (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700006; and Certification Form GPH2)

297. Letter, dated March 9, 2007, from GZA to City of Waterbury Water Pollution Control re: Minor Photographic Processing Wastewater Discharge at Saint Mary's Hospital

298. 1996 Industrial/Commercial Sewer Use Certification Statements for Saint Mary's Hospital and its related properties

299. 1995 Sewer User Certification Statement for Saint Mary's Hospital

300. Materials License, No. 06-00679-01, dated April 24, 2007, issued by the U.S. Nuclear Regulatory Commission (as amended by Amendment No. 55)

301. Ionizing Radiation Registration, dated December 30, 2009; Submitted to the CT DEP on January 1, 2010

302. Saint Mary's Hazardous Waste Disposal (Radioactive) Policy, revised April 2006

303. Saint Mary's Radioactive Contaminated Objects Waste Disposal Policy, dated December 2010

304. Hazardous Substance Certificate and Indemnification Agreement, dated June 28, 1991

305. Phase II Subsurface Investigations Report, 51 North Elm Street, Waterbury, Connecticut, dated July 26, 2007, prepared by HRP Associates, Inc.

306. Subsurface Investigation Report, dated January 11, 2008, prepared by GeoInsight for 51 North Elm Street, Waterbury, Connecticut

307. Memorandum, dated January 14, 2008, prepared by GeoInsight re: break down of the estimated remediation costs for 51 North Elm Street, Waterbury, Connecticut

308. Letter, dated February 1, 2008, from GeoInsight re: proposal for subsurface remedial investigation, design, and implementation services for 51 North Elm Street, Waterbury, Connecticut

309. Escrow and Release Agreement, dated February 11, 2008, for 51 North Elm Street, Waterbury, Connecticut

310. Memorandum, dated February 14, 2008, from GeoInsight re: Proposed Work Schedule for 51 North Elm Street, Waterbury, Connecticut

311. HRP Associates, Inc.'s Proposal for Oversight of the Environmental Remediation That Has Been Proposed by GeoInsight for 51 North Elm Street, Waterbury, Connecticut, dated March 18, 2008

312. HRP Invoice, dated October 9, 2008, for Project Management Services

313. E-mail, dated February 27, 2009, from HRP Associates, Inc. re: completion of soil remediation at 51 North Elm Street, Waterbury, Connecticut

314. Memorandum, dated March 20, 2009, from GeoInsight re: Pavement Restoration and Compliance/Post Remedial Ground Water Monitoring at 51 North Elm Street, Waterbury, Connecticut

315. E-mails, dated May 13, 2010, May 21, 2010, and May 24, 2010 re: partial disbursement of environmental escrow and retention of $25,000 for 51 North Elm Street, Waterbury, Connecticut

316. Letter, dated June 23, 2010, enclosing a check representing the agreed amount of the environmental escrow release for 51 North Elm Street

317. Payment Notice, dated October 7, 2010, re: GeoInsight invoices for environmental remediation services at 51 North Elm Street, Waterbury, Connecticut

318. E-mail, dated December 22, 2010, from GeoInsight re: 51 North Elm Street-Status of Ground Water Monitoring

319. Saint Mary's Preliminary Mold Inspection of Slocum and Xavier 5, dated January 26, 2006

320. Saint Mary's Preliminary Mold Inspection of Kenny 3, dated September 12, 2006

321. Saint Mary's Preliminary Mold Inspection of Sacred Heart Basement, dated September 14, 2006

322. Mold Environmental Monitoring Report, dated October 15, 2007, prepared by Praxair

323. Mold and Fungi Inspection Report, dated June 4, 2010, prepared by Superior Industries L.L.C.

324. Certificate of Mold Analysis, dated February 10, 2010, prepared by Pro Lab

325. Mold and Fungi Inspection Report, dated July 25, 2008, prepared by Superior Industries L.L.C.

326. Certificates of Mold Analysis, dated July 7, 2008, prepared by Pro-Lab

327. Mold and Fungi Remediation Recommendation Report, dated January 21, 2009, prepared by Superior Industries L.L.C.

328. Mold and Fungi Remediation Recommendation Report, dated May 20, 2009, prepared by Superior Industries L.L.C.

329. Mold and Fungi Inspection Report, dated September 20, 2010, prepared by Superior Industries L.L.C.

330. Certificates of Mold Analysis and Mold Analysis Reports for Pediatric Ward, dated June 25, 2008, prepared by Pro-Lab

331. Lead Analysis Report, dated April 6, 2007, for Drinking Water Child Care Area

332. Raydon and Lead Testing Recommendation Report, dated February 20, 2009, re: Children's Day Care Center

333. Environmental Monitoring at Saint Mary's Hospital, dated September 2006, prepared by Praxair

334. Environmental Monitoring at Saint Mary's Hospital, dated March 2007, prepared by Praxair

335. Environmental Monitoring Reports for anesthetic waste gas, air change rate, ethylene oxide, and fume hood, dated March 2010, prepared by Praxair

336. Laboratory Report – Full Particle Identification for Saint Mary's Hospital Lobby, dated February 5, 2008, prepared by EMSL Analytical, Inc.

337. Fire Marshall Inspection Certificates/Reports for 1994-2010

338. Policyholder Environment of Care Review and Risk Improvement Report, dated February 23, 2010, prepared by Zurich Services Corp.

339. Policyholder Environment of Care Review and Risk Improvement Report, dated April 21, 2009

340. Policyholder Environment of Care Review and Risk Improvement Report, dated May 13, 2008

341. Policyholder Environment of Care Review and Risk Improvement Report, dated May 8, 2007

342. Utilities Management Program for Plant Operations Department

343. Saint Mary's Hospital Environmental Compliance Assistance (internal guidelines)

344. Contract of Sale between Saint Mary's Hospital Corporation and Tom Gessler for Parcel 10B, Abbott Terrace in Waterbury, Connecticut (undated)

345. Phase I Environmental Site Assessment of Saint Mary's Hospital & Adjacent Facilities, dated February 26, 2011, prepared by Environmental Risk Services, LLC (including all Appendices)

346. Letter, dated February 24, 2011, from Environmental Risk Services, LLC to Gobbell Hays Partners, Inc. re: Environmental Summary Report for 290 French Street, Watertown, CT

347. Hazardous Materials Survey Report, dated August 10, 2011, prepared by HRP Associates, Inc.

348. Limited Asbestos—Containing Materials Survey Report, SMRI

349. Sacred Heart Cafeteria Serving Area, dated September 27, 2011, prepared by HRP Associates, Inc.

350. Environmental Reviewed and Phase II Subsurface Investigations Report, dated June 28. 2011, prepared by HRP Associates, Inc.

351. Phase III Subsurface Investigations Report, dated September 28. 2011, prepared by HRP Associates, Inc. (attached as Phase III)

352. Additional Phase III Subsurface Investigations Report, dated March 2, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Additional Phase III Report)

353. Closure Report for Former Less Than 180 Day Hazardous Waste Container Storage Area, dated July 17, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Closure Report)

354. Hazardous Materials Survey Report, dated October 4, 2011, prepared by HRP Associates, Inc.

355. Phase I Environmental Site Assessment Report, dated October 4, 2011, prepared by HRP Associates, Inc.

356. Limited Ground Penetrating Radar (GPR) Survey Report, dated October 11, 2011, prepared by HRP Associates, Inc.

357. 2013 General Permit to Limit Potential to Emit - Annual Compliance Certification Form, dated March 20, 2014

358. 2014 General Permit to Limit Potential to Emit - Emissions Calculator for 2014 Calendar Year, dated February 2015

359. 2013 Tier2 Chemical Inventory Report, dated March 26, 2014

360. 2014 Tier2 Chemical Inventory Report, dated February 18, 2015

Schedule 6.22

Employee Benefit Matters

6.22(a)

1. Paid Time Off (used for vacation, holiday, personal, and sick time)
2. Bereavement Leave
3. Jury Duty Leave
4. Military Duty Leave
5. Pregnancy Leave
6. Donated Time
7. Employee Assistance Plan
8. Health Plan (self-insured)
9. Dental Plan (self-insured)
10. Basic Life Insurance
11. Supplemental Life Insurance
12. Dependent Life Insurance for spouse and/or dependent(s)
13. Short Term Disability
14. Long Term Disability
15. Basic Accidental Death & Dismemberment
16. Voluntary Accidental Death & Dismemberment
17. Discounted YMCA membership
18. Saint Mary's Hospital Retirement Savings Plan
19. Pension Plan for Employees of St. Mary's Hospital Corporation
20. Home & Auto Insurance (paid through payroll deduction)
21. On-site Parking (paid through payroll deduction)
22. Health Care Professional Liability Insurance
23. Excess Medical Professional Liability Insurance

24. Annual License Renewal

25. Flexible Spending Account
    a. Medical
    b. Dependent Care

26. Tuition Reimbursement

27. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan

28. Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plan

29. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013

30. Non-Competition and Severance Agreement for Executive by and between Saint Mary's Hospital, Inc. and Steven Schneider, M.D., dated May 25, 2011

31. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Michael Novak, dated June 20, 2008, as amended

32. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Ralph W. Becker, dated January 27, 2014

33. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital, Inc. and Charles M. Flinn, dated December 12, 2013

34. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and James B. Tucker, dated August 8, 2013

35. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008, as amended

36. Amended and Restated Non-Competition and Severance Agreement for a Director by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008, as amended

37. Retiree medical (self-insured)

38. Retiree life insurance

39. Executive Incentive Plans

To the knowledge of Saint Mary's, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health.

6.22(b)

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

A submission under the IRS's VCP was filed for each of the 401(k) Plan and Pension Plan with the most recent IRS determination letter submission for the plan to correct untimely amendments. A Compliance Statement from the IRS in connection with the VCP submission for the 401(k) Plan was issued on September 14, 2011. A Compliance Statement from the IRS in connection with the VCP submission for the Pension Plan was issued on July 25, 2011.

6.22(c)

None, provided the church plan exemption as described in Schedule 6.07 is legally valid and in effect for the Pension Plan for Employees of St. Mary's Hospital Corporation.

6.22(d)

None.

6.22(e)

The following St. Mary's Benefit Plans are intended to be "church plans:"

St. Mary's Hospital Retirement Savings Plan

Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan")

All health and welfare plans

The Pension Plan's funded status is materially below the 80% standard set forth in the Agreement section 6.22(e), and for which an Agreement Disclosure Schedule exception is now taken.

6.22(f)

All Saint Mary's welfare benefit plans have been considered and treated as exempt Church Plans.

Saint Mary's provides retiree medical and life insurance benefits.

6.22(g)

1. Amended and Restated Non-Competition and Severance Agreement, as amended, by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008
2. Amended and Restated Non-Competition and Severance Agreement for a Vice President, as amended, by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008
3. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Michael Novak, dated June 20, 2008
4. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Steven Schneider, M.D., dated May 25, 2011
5. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Ralph W. Becker, dated January 27, 2014
6. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Charles M. Flinn, dated December 12, 2013
7. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and James B. Tucker, dated August 8, 2013
8. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013
9. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan and Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plans
10. Executive Incentive Plans

6.22(h)

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be

requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.22(k)

None.

Schedule 6.23

Employment Matters

None.

Schedule 6.24

Taxes

1. Failed to file 2009 Form 990 for the Heart Center of Greater Waterbury, Inc.

2. Saint Mary's Hospital was audited by the State of Connecticut for Sales and Use Tax in early 2010 for the calendar years from 12/31/2004 to 12/312009. The Hospital did not remit sales tax collected on certain contract revenues. The audit resulted in a tax of $7,159.86 with penalties and interest of $3,406.15 for a total of $10,566.01. Such tax was paid in full. The Hospital now files those tax returns every year and remits to the State

Schedule 6.25

Insurance

Complete List of Current Insurance/Self-Insurance Policies

1. Workers Compensation and Employers Liability Insurance Policy - Pennsylvania Manufacturers Indemnity Company

2. For all additional policies, see attached.

Pending Claims and Claims History for 10 Year Period Prior to Signing Date

See Attachment to Schedule 6.25

Saint Mary's Health System, Inc.

Summary of Insurance Effective as of July 1, 2015
People's United Insurance Agency

Company	Policy Number	Policy Period	Annual Premium
American Guarantee & Liability Ins Co. (Zurich)	ZMD353933914	10/01/14-15	$191,805 (Includes $3,000 Engineering Fee)

PROPERTY

Coverage	Limit	Deductible
Blanket Building & Business Personal Property		
56 Franklin St Campus & Other Locations per Statement of Values	$375,000,000	$25,000
Business Interruption	Included	
Extra Expense	25,000,000	
Machinery Breakdown	150,000,000	25,000
Earthquake	100,000,000	50,000
Flood	100,000,000	50,000

American Guarantee & Liability Ins Co	BAP932700901	10/01/14-15	$16,330

AUTOMOBILE

Limits	
Bodily Injury & Property Damage Limit (Incl. Hired & Non Owned)	$1,000,000
Medical Payments	$5,000
Uninsured & Underinsured Motorist (Conversion)	$1,000,000
Comprehensive Deductible (full glass)	$500
Collision Deductible	$1,000

Additional Coverage and Exclusions

Rental Reimbursement	$30 Day/$900 Max
Primary Hired Auto Physical Damage	$50,000
Commercial Auto Extension Endorsement	Included
Ambulance and/or Emergency Vehicles	Excluded

GARAGE KEEPERS – DIRECT PRIMARY

Locations:

1. 56 Franklin Street, Waterbury, CT
2. 88 Union Street, Waterbury, CT
3. 133 Scovill Street, Waterbury, CT
4. 100 Union Street, Waterbury, CT
5. 353 East Main Street, Waterbury, CT

Garagekeepers Limit – Each Location

$75,000 Comprehensive ($500 deductible/$2,500 max)
$75,000 Collision ($500 deductible)

Global Aerospace, Inc.	10041881	10/01/14-15	$14,025

HELIPORT LIABILITY

Limits

$10,000,000	Each Occurrence
$ 25,000	Fire Damage Limit (Any One Fire)
$ 10,000	Medical Expense (Any One Person)
$10,000,000	Non Owned Aircraft Liability

ProSelect Insurance Company	PSCCA10201402	10/01/14-15	$935,000

EXCESS LIABILITY

Reinsured: - Saint Mary's Indemnity Company LLC

Limits

$15,000,000	Health Care Professional Liability - Specific Loss Limit
$15,000,000	Health Care Professional Liability - Aggregate Limit
$25,000,000	Other Coverage (GL) – Specific Loss Limit
$25,000,000	Other Coverage (GL) - Aggregate Limit

Underlying Limits

$3,000,000/$14,000,000	Professional Liability (Claims-Made)
$1,000,000/$4,000,000	General Liability (Occurrence)
$1,000,000/$1,000,000	Employee Benefits Liability
$1,000,000	Automobile Liability
$1,000,000/$1,000,000/$1,000,000	Employers Liability
$10,000,000	Helipad Liability
$1,000,000/$2,000,000	Child Development Center General Liability (Occurrence)

Allied World Assurance Company	03086025	10/01/14-15	$50,000

Excess Liability

Limits $5,000,000 XS $15,000,000 Health Care Professional Liability

National Union Fire Insurance Co. of Pittsburgh PA 015933607 10/01/14-15 $110,630

DIRECTORS & OFFICERS LIABILITY/EMPLOYMENT PRACTICES LIABILITY (CLAIMS-MADE)

Limits expenses)	$15,000,000	Each Claim or related Claims and in the policy aggregate (inclusive of defense
	$500,000	EMTALA
	$500,000	HIPAA
Retentions		
	$ 0	Insured Persons
	$250,000	Corporate Indemnification & Insured Entity
	$350,000	Anti-Trust with 75/25 Coinsurance
	$200,000	Employment Practices Liability & Third Party EPL

Allied World National Assurance Company 03059844 10/01/14-15 $20,790

DIRECTORS & OFFICERS SIDE A LIABILITY (CLAIMS-MADE)

Limits	$5,000,000	excess $15,000,000 National Union Fire

Illinois National Insurance Company 02-778-21-50 1/30/15-16 $27,286

FIDUCIARY LIABILITY	$5,000,000	Limit
DEDUCTIBLE	$25,000	

Travelers Casualty & Surety Co. of America 105686950 10/01/14-15 $17,150

CRIME

Limits

$5,000,000	Employee Theft
$5,000,000	ERISA
$5,000,000	Forgery or Alteration
$5,000,000	On Premises
$5,000,000	In Transit
$5,000,000	Money Orders & Counterfeit Money
$5,000,000	Computer Fraud
$100,000	Computer Program & Electronic Data Restoration Expense
$5,000,000	Funds Transfer Fraud
$10,000	Theft of Client Property
$10,000	Theft of Patient Property
$1,000,000	Personal Accounts Forgery or Alteration
$10,000	Claim Expense

DEDUCTIBLES

$ 50,000	
$ 0	ERISA & Claim Expense
$ 500	Theft of Client & Patient Property
$ 1,000	Computer Program & Electronic Data Restoration Expense

KIDNAP & RANSOM

$5,000,000	Kidnap for Ransom
$5,000,000	Extortion for Ransom

IDENTITY FRAUD EXPENSE

$ 25,000	Limit

Beazley/Lloyd's	W104CB150601	1/01/15-16	$49,400 Includes Tax

NETWORK SECURITY/BREACH RESPONSE "CLAIMS MADE"

Limits:	$3,000,000	Per Claim and in the Aggregate, inclusive of:
	3,000,000	Information Security and Privacy Liability
	3,000,000	Website Content Liability
	1,500,000	Regulatory Action Defense & Penalties
	3,000,000	Security Event Data Restoration
	3,000,000	Cyber Extortion
	2,500,000	Aggregate Limit for all Computer Expert Services, Legal Services and Public Relations and Crisis Management Expenses
	250,000	PCI Fines & Penalty Coverage
Retention:	$ 50,000	Per Claim
Includes:	Privacy Breach Response Services, subject to $10,000 Retention each breach: Notification of up to 2 Million Individuals Credit Monitoring for breaches with obligation to notify 100 or more individuals	

Ironshore Specialty Insurance Company (3 Yrs)	000970501	10/01/12–15	$48,338 est. Includes Tax

POLLUTION LEGAL LIABILITY

Limits:	$3,000,000	Third Party Claims for Bodily Injury, Property Damage and Remediation Expenses
	$3,000,000	First Party Remediation Expenses
	$3,000,000	Emergency Response Expenses
	$3,000,000	Business Interruption, 365 Days
	$3,000,000	Disinfection Event Expenses
	$3,000,000	Evacuation Expenses
Deductibles:	$25,000	Each Incident
	5 Days	Business Interruption

Ace American Insurance Company	G24796012001	10/01/14-15	$1,547

STORAGE TANK LIABILITY – Financial Responsibility

Limits:	$1,000,000	Per Storage Tank Incident – Claims & Remediation Costs
	$1,000,000	Aggregate – Claims & Remediation Costs
	$1,000,000	Aggregate Limit for all Legal Defense Expenses
	$2,000,000	Total Policy Aggregate
Deductible:	$5,000	Per Incident

The Travelers Indemnity Company of CT	6607D013207	10/01/14-15	$2,882

GENERAL LIABILITY – CHILD DEVELOPMENT CENTER

General Liability Limit

$2,000,000	Aggregate
2,000,000	Products/Completed Operations Aggregate
1,000,000	Personal & Advertising Injury
1,000,000	Each Occurrence
300,000	Damage to Premises Rented to You
5,000	Medical Expense (excludes children in daycare program)

Abuse/Molestation Limit

2,000,000	Aggregate
1,000,000	Each Abuse or Molestation Offense

Hartford Life and Accident Insurance Company	02SR365272	10/01/14-15	$340

SPECIAL RISK ACCIDENT – CHILD DEVELOPMENT CENTER

Limits:

$ 5,000	Accidental Death Benefit
10,000	Accidental Dismemberment Benefit
35,000	Catastrophe Benefit
25,000	Accident Medical Expense Benefit
1,000	Dental Limit

Schedule 7.04

Conflicts - Trinity Health and NE-RHM

Consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Trinity Health and NE-RHM in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transactions contemplated hereby and thereby:

Roman Catholic Archdiocese of Hartford
Holy See, Roman Catholic Church
State of Connecticut Office of HealthCare Access
Office of the Attorney General of the State of Connecticut
Federal Trade Commission

Schedule 7.08(a)

Compliance with Laws - NE-RHM

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC is reviewing the letter and expects to appeal.

Schedule 7.09(a)

Medicare - Plans of Correction - NE-RHM

Saint Francis Hospital and Medical Center had its tri-annual Joint Commission survey on October 21-24, 2014. We are in process of submitting corrective action plans which are due by December 20, 2014 and January 4, 2014. A follow-up visit occurred on December 4, 2014 to validate compliance with certain Conditions of Participation and the Joint Commission concluded Saint Francis Hospital and Medical Center was in compliance. A follow up visit was conducted by the Joint Commission on June 22-23, 2015. Full compliance with all standards was identified with no further actions required.

The Department of Public conducted a CMS validation survey beginning November 24, 2014. The Department of Public Health identified Saint Francis Hospital and Medical Center was in full CMS compliance.

Mount Sinai Rehabilitation Hospital had its tri-annual Joint Commission survey on December 1st and 2nd of 2014. The report has been received, full compliance with CMS standards was identified and the evidence of Joint Commission standards compliance was submitted by the due dates of January 16, 2015 (45 day plan) and January 31, 2015 (60 day plan). Full compliance with Joint Commission standards was identified by the Joint Commission with acceptance of completed plans and data metrics on June 2, 2015.

Schedule 7.09(b)

Medicare/Medicaid Claims - NE-RHM

None.

Schedule 7.12

HIPAA - Breach Notifications - NE-RHM

Date of Occurrence	Description	Status
11/10/2014	Theft of camera at Access Center	A breach notification has not yet been made regarding this occurrence, as Saint Francis is still completing its internal investigation. Incident reported in the 2015 Annual Report to OCR.
10/24/2014	Inappropriate Access to PHI	Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR.
9/23/2014	Stolen Laptop	Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR.
12/27/2013	Paper records with certain patient information stolen from physician's vehicle	There have been two requests for information from the Office of Civil Rights regarding this occurrence and Saint Francis has responded to both requests. OCR has closed this matter. Refer to 6.14(a).

Schedule 8.08(a)

Insured Real Property

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

2. Parcel Two

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

3. Parcel Three

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

4. Parcel Four

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

5. Parcel Five

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

6. Parcel Six

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

7. Parcel Seven

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

8. Parcel Eight

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

9. Parcel Nine

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

10. Parcel Ten

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

11. Parcel Eleven

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

12. Parcel Twelve

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

13. Parcel Thirteen

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

14. Parcel Fourteen

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

15. Parcel Fifteen

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

16. Parcel Sixteen

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

17. Parcel Seventeen

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

18. <u>Parcel Eighteen</u>

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

NORTHERLY:	79 feet on East Main Street
EASTERLY:	136 feet on Second Piece;
SOUTHERLY:	on land now or formerly of The Church of the Immaculate Conception; and
WESTERLY:	136 feet on land now or formerly of The Church of the Immaculate Conception.

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

NORTHERLY:	28.00 feet, more or less, by East Main Street;
EASTERLY:	130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street;
SOUTHERLY:	20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and
WESTERLY:	136.00 feet by land of Philip Avery.

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

NORTHEASTERLY:	19.86 feet by East Main Street;
SOUTHEASTERLY:	136.00 feet by land now or formerly of Philip Veillette, et al;
NORTHEASTERLY:	again 99.25 feet by land now or formerly of Philip Veillette, et
SOUTHEASTERLY:	al; again 43 feet, more or less, by Baldwin Street, fka Mill
SOUTHEASTERLY:	Street; again
SOUTHWESTERLY:	by Baldwin Street, fka Mill Street;
NORTHWESTERLY:	251.25 feet by land now or formerly of the Church of the Immaculate Conception; 136.68 feet by land now or formerly of the Church of the Immaculate Conception.

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

Office of the President
Chad W. Wable, FACHE

Saint Mary's
HEALTH SYSTEM

September 18, 2015

JANEANNE LUBIN-SZAFRANSKI
SAINT FRANCIS CARE, INC.
114 WOODLAND ST
HARTFORD, CT 06105

TRINITY HEALTH CORPORATION
20555 VICTOR PARKWAY
LIVONIA, MI 48152

RE: Supplemental Disclosure Letter

Dear Ms. Lubin-Szafranski:

In connection with the Transfer Agreement, dated September 18, 2015, by and among Saint Francis Care, Inc. ("Saint Francis"), Trinity Health Corporation ("Trinity"), Saint Mary's Health System, Inc., and Saint Mary's Hospital, Inc. ("Saint Mary's") (collectively, the "Parties"), Saint Mary's has requested to make several supplemental disclosures herein and Trinity Health and Saint Francis have agreed thereto. By signing below, the Parties agree the below disclosures are valid disclosures to the Transfer Agreement and have the same force and effect as the Transfer Agreement Disclosure Schedules. Based on the foregoing, Saint Mary's makes the following supplemental disclosures:

6.15

[redacted]

6.19:

Initial Breach Report, dated February 28, 2014, individual patient - unauthorized access/disclosure

Initial Breach Report, dated February 28, 2014, five patients affected - mail incorrectly addressed

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(f):

Policies and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(k):

Saint Mary's Hospital has a number of individual non-competition, non-disclosure and severance payment agreements in effect with a number of Officers and Executives of Saint Mary's Hospital. The Agreements, and certain amendments, are generally dated from 2008 to 2014. The severance payment obligations vary by agreement and often are measured based on years of service at the time of termination with maximum dollar amount limits. However, because the individual payments by Saint Mary's Hospital are incurred for employment terminations which occur with or without cause, and because the agreements contain required terminated employee release of claims provisions for the payments to occur, it appears likely that Section 409A compliance issues will therefore exist. Such Agreements may be viewed by the IRS as deferred compensation agreements in substance, and because of the required releases of claims, as well as the total amounts to be paid by Saint Mary's Hospital, IRS Notices 2010-6 and 2010-80 may provide relief for any desired amendments to be implemented for purposes of complying with Section 409A, and so as to legally avoid potential IRS penalties, individual income tax liabilities, interest and non-payment penalties.

Very truly yours,

Dated: 9-18-15, 2015

SAINT MARY'S HEALTH SYSTEM, INC.

By: _____
Name: Chad W. Wible, FACHE
Title: Chief Executive Officer

Dated: 9-18-15, 2015

TRINITY HEALTH CORPORATION

By: _____
Name:
Title:

Dated: 9-18-15, 2015

SAINT FRANCIS CARE, INC.

By: _____
Name:
Title:

Dated: 9-18-15, 2015

TRINITY HEALTH CORPORATION

By: _____
Name:
Title:

Dated: 9-18-15, 2015

SAINT FRANCIS CARE, INC.

By: _____
Name:
Title:

CLOSING DISCLOSURE SCHEDULE

This Closing Disclosure Schedule is being delivered in anticipation of Closing pursuant to Section 5.01 the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Trinity Health – New England, Inc. (f/k/a Saint Francis Care, Inc.), a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**).

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

DISCLOSURE SCHEDULES

Schedule 1A _____ Knowledge of Saint Mary's
Schedule 1B _____ Knowledge of NE-RHM
Schedule 1C _____ Knowledge of Trinity Health
Schedule 2.01 _____ SMH Board Members
Schedule 3.02 _____ NE-RHM Board of Directors - Saint Mary's Members
Schedule 6.04 _____ Conflicts/Consents
Schedule 6.05 _____ Organizational Chart
Schedule 6.07 _____ Undisclosed Liabilities
Schedule 6.08 _____ Absence of Certain Changes, Events, Conditions
Schedule 6.09 _____ Material Contracts
Schedule 6.09(c) _____ Material Contracts - Validity
Schedule 6.10 _____ Permitted Encumbrances
Schedule 6.11 _____ Condition and Sufficiency of the Saint Mary's Assets
Schedule 6.12(a) _____ Owned Real Property
Schedule 6.12(b) _____ Leased Real Property
Schedule 6.14(a) _____ Legal Proceedings
Schedule 6.14(b) _____ Governmental Orders
Schedule 6.15(a) _____ Compliance With Laws
Schedule 6.16(a) _____ Medicare - Plans of Correction
Schedule 6.16(b) _____ Medicare - Claims
Schedule 6.16(d) _____ Medicare - Accreditation Surveys/Deficiency List
Schedule 6.19 _____ HIPAA - Breach Notifications
Schedule 6.20 _____ Affiliate Transactions
Schedule 6.21(e) _____ Environmental
Schedule 6.22(a) _____ Employee Benefit Plans
Schedule 6.22(b) _____ Benefit Plans - Compliance
Schedule 6.22(c) _____ Employee Pension Benefit Plan Liability
Schedule 6.22(d) _____ Multiemployer Plan Liability
Schedule 6.22(e) _____ Church Plans
Schedule 6.22(f) _____ Employee Welfare Benefit Plans
Schedule 6.22(g) _____ Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans

Schedule 6.23 _____ Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

Schedule 1A

Knowledge of Saint Mary's

No updates.

Schedule 1B

Knowledge of NE-RHM

1. Christopher M. Dadlez, President and CEO
2. David Bittner, Senior Vice President and CFO
3. Janeanne C. Lubin-Szafranski, Senior Vice President and General Counsel
4. Jennifer S. Schneider, Vice President of Finance

Schedule 1C

Knowledge of Trinity Health

No updates.

Schedule 2.01

SMH Board Members

Directors and Officers

- Mengacci, Esq., Joseph
- Pugh, Richard
- Wable, Chad
- Mattie, Angela
- Roscoe, Robert

Directors

- Albert, Eric
- Albini, M.D., S. Mark
- Bachhuber, Theresa M.
- Ford, Father Christopher
- Gumbardo, M.D., Robert
- Richi, M.D., Aziz
- Rodriguez, Felix
- Roer, M.D., David
- Sullivan, Esq., Christine
- Summa, Esq., Kara

Schedule 3.02

Board of Directors of NE-RHM - Saint Mary's Members

Notwithstanding the provisions of the Transfer Agreement, the Parties hereto agree that the following individuals will be added to the Board of Directors of NE-RHM effective as of September 1, 2016:

Garret Casey, Jr.

Stephen R. Griffin, Esq.

Schedule 6.04

Conflicts/Consents

(a) No updates.

(b) No updates.

(c)(i) No updates.

(1) Waterbury Hospital, as member of the Harold Leever Regional Cancer Center, Inc., provided consent in September 2015. Waterbury Hospital and SMH recently filed a CON modification in anticipation of the transaction contemplated in the Transfer Agreement.

(2) NVRA consent provided to NE-RHM and Trinity Health

(3) Notice to DSS required within 35 days post-closing

(4) Craneware consent letter sent out. Awaiting receipt

(5) Notice letter to McKesson provided to NE-RHM, Trinity Health

(6)

a. Consent of Archdiocese provided to NE-RHM, Trinity Health.
b. Consent of Holy See, Roman Catholic Church provided to NE-RHM, Trinity Health
c. OHCA approval received and provided to all parties
d. Notice provided to Connecticut Attorney General
e. FTC did not provide comment

(7) Upon further review, consent of Diagnostic Imaging of Southbury, LLC is not required.

(8) Per Section 10.01 of the Indenture of Lease by and between Park West, LLC and Saint Mary's Hospital, Park West, LLC required consent to transfer the Indenture of Lease. Proof of Park West, LLC's consent to the transfer has been provided to NE-RHM and Trinity Health.

(9) Per Section 21(a) of the Lease by and between RPH Highland LLC and Saint Mary's Hospital, RPG Highland LLC required consent to assign the Lease. Proof of RPH Highland LLC's consent to the assignment has been provided to NE-RHM and Trinity Health.

(c)(ii) No updates.

(c)(iii) No updates.

(c)(iv) No updates.

(c)(v) Pursuant to Section 18.d. of the Master Service Agreement, dated January 5, 2009, by and between SMH and Connecticut Children's Medical Center ("CCMC"), CCMC may terminate the Master Service Agreement by providing written notice to SMH upon a Change of Control. Change of Control includes a change in the membership of SMH. SMH and CCMC remain on good terms and CCMC is not terminating the agreement.

(d) No updates.

Schedule 6.05

Organizational Chart

No updates.

Schedule 6.07

Undisclosed Liabilities

Webster Loan to be paid on August 1, 2016 and all necessary releases filed thereafter.

Schedule 6.08

Absence of Certain Changes, Events, Conditions

Schedule 6.08 is limited to changes, events, conditions from Balance Sheet Date (6/30/2015) until Signature Date (9/18/15) and thus no update is required

Schedule 6.09

Material Contracts

(i) Each Contract involving aggregate consideration in excess of $100,000

See attached.

(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000

1. Purchase and Sale Agreement by and between Peter Greco, M.D., Thomas Greco, M.D., and Saint Mary's Health System, Inc., for the Units 3-G and 3-F in the Medical Office Building located at 133 Scovill Street in Waterbury, CT.

(iii) All Contracts with any Governmental Authority

No updates.

(iv) Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement

No updates.

(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand

No updates.

(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party

No updates.

(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000

No updates.

SAINT MARY'S HOSPITAL ATTACHMENT TO CLOSING SCHEDULE 6.09(a)(i)

CONTRACT NUMBER	VENDOR OTHER PARTY
1001.1319C	Yale University School of Medicine
1001.1323C	Press Ganey
1001.1326E	PAC Planning Services, LLC
1002.1328C	Michael Malinics, MD
1002.1330C	Mary L. Aquavia, MD
1001.1341E	NVLM, Inc
1001.1351C	Berkeley Research Group (BRG)
1002.1354C	Pruner, Joseph MD
1001.1355C	Surgical Monitoring Services, Inc. d/b/a Sentient
1002.1358C	Ghisa, MD Adriana
1002.1368C	Nicolescu, Mirela MD
1002.1372C	1389 West Main Street, Suite 224, Waterbury CT
1002.1370C	Gniadek, Thomas MD
1002.1371C	Gniadek, Thomas MD Asset Purchase Agreement
1001.1381C	H2C (Hammond)
1002.1382C	Kett, Kevin MD
1002.1383C	Chang, MD Yueming
1001.1385C	RelayHealth
1002.1389C	United Health Care
1001.1401C	Atrion Networking Corporation
1001.1409C	Medtronic, Inc.
1002.1410C	Singanamala, MD Santhi
1002.1417C	Patel, MD Kush

1002.1416C	Rosado, MD Ana
1002.1418C	Cheema, Rabia
1002.1420C	1389 West Main Street, Suite 224, Waterbury CT 06708
1002.1421C	Shetty, Shopa MD
1002.1423C	Gnanaraj, Joseph MD

UPDATE TO SCHEDULE 6.09(a)(i) AS REFLECTED IN INITIAL DISCLOSURE SCHEDULES

MASTER COMMERCIAL CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1002C	Saint Mary's Hospital	Geonetric Technology
1001.1007E	Saint Mary's Hospital	McKesson Corporation
1001.1008E	Saint Mary's Hospital	McKesson Corporation
1001.1009E	Saint Mary's Hospital	McKesson Corporation
1001.1012C	Saint Mary's Hospital	McKesson Corporation
1001.1016C	Saint Mary's Hospital	Medtronic, Inc.
1001.1017C	Saint Mary's Hospital	Medtronic, Inc.
1001.1019C	Saint Mary's Hospital	Quinnipiac University
1001.1024E	Saint Mary's Hospital	Nuance Powerscribe
1001.1025E	Saint Mary's Hospital	Naugatuck Valley Community College
1001.1050C	Saint Mary's Hospital	RelayHealth
1001.1053C	Saint Mary's Hospital	RelayHealth
1001.1054C	Saint Mary's Hospital	Connecticut Hospital Association
1001.1060C	Saint Mary's Hospital	Roche Diagnostics Corporation
1001.1063E	Saint Mary's Hospital	Nuance Communications, Inc.
1001.1064E	Saint Mary's Hospital	McKesson Corporation
1001.1065C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1071C	Saint Mary's Hospital	Leidos Health LLC
1001.1085C	Saint Mary's Hospital	JVK Operations
1001.1092C	Saint Mary's Hospital	WB Mason
1001.1099C	Saint Mary's Physician Partners, LLC	Naugatuck Valley Women's Health Specialists, PC
1001.1100E	Saint Mary's Hospital	Wellsoft Corporation
1001.1120C	Saint Mary's Hospital	Medtronic USA, Inc.
1001.1121C	Saint Mary's Hospital	Allscripts Healthcare, LLC
1001.1160C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.1165C	Saint Mary's Hospital	Kronos
1001.1168C	Saint Mary's Hospital	Siemens Healthcare Diagnostics Inc.
1001.1171C	Saint Mary's Hospital	Grainger Industrial Supply
1001.1173C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.1177C	Saint Mary's Hospital	Truven Health
1001.1178C	Saint Mary's Hospital	Spendadvisor
1001.1185C	Saint Mary's Hospital	Universal Background Screening
1001.1189C	Saint Mary's Hospital	Intuitive Surgical, Inc.

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1191C	Saint Mary's Hospital	Beckman Coulter
1001.1193C	Saint Mary's Hospital	Draeger Medical, Inc.
1001.1204C	Saint Mary's Hospital	Cross Country Staffing
1001.1221C	Saint Mary's Hospital	Bard Peripheral Vascular, Inc.
1001.1225C	Saint Mary's Hospital	NVMRI
1001.1226C	Saint Mary's Hospital	Edwards Lifesciences LLC
1001.1237C	Saint Mary's Hospital	Covidien Sales, LLC
1001.1248C	Saint Mary's Hospital	McKesson Technologies, Inc.
1001.1250C	Saint Mary's Hospital	St. Jude Medical
1001.1274C	Saint Mary's Hospital	PMA Management Corp. of New England
1001.1275C	Saint Mary's Hospital	Neuro Enterprises, LLC
1001.1286C	Saint Mary's Hospital	Baxter Healthcare Corporation
1001.190C	Saint Mary's Hospital	St Jude Medical US Division
1001.210C	Saint Mary's Hospital	Craneware, Inc.
1001.216C	Saint Mary's Hospital	University of Connecticut School of Medicine
1001.219C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.228C	Saint Mary's Hospital	Naugatuck Valley Lawn Maintenance, Inc.
1001.235E	Saint Mary's Hospital	School Readiness Grant Program
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.287C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.304E	Saint Mary's Hospital	Stryker
1001.332C	Saint Mary's Hospital	Heart Center of Greater Waterbury, Inc.
1001.354E	Saint Mary's Hospital	Sodexho Operations, LLC
1001.367E	Saint Mary's Hospital	Yale University School of Medicine
1001.393C	Saint Mary's Hospital	3M Health Care Service Center
1001.411C	Saint Mary's Hospital	Cardinal Health 200, LLC
1001.420C	Saint Mary's Hospital	Western Connecticut State University
1001.427C	Saint Mary's Hospital	Sodexho Operations, LLC
1001.430C	Saint Mary's Hospital	Yale University School of Medicine
1001.433C	Saint Mary's Hospital	Yale University School of Medicine
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.44C	Saint Mary's Hospital	Toshiba America Medical Systems Inc.
1001.468C	Saint Mary's Hospital	University of Connecticut, Department of Allied Health Sciences
1001.469C	Saint Mary's Hospital	University of Connecticut School of Nursing
1001.474C	Saint Mary's Hospital	Haemonetics Corporation
1001.47C	Saint Mary's Hospital	Siemens Medical Solutions USA, Inc.
1001.482C	Saint Mary's Hospital	Department of Public Health
1001.489C	Saint Mary's Hospital	Gateway Community College

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.490C	Saint Mary's Hospital & Health System	Santa Buckley Energy, Inc.
1001.495E	Saint Mary's Hospital	GE Healthcare
1001.519C	Saint Mary's Hospital	University of Connecticut School of Social Work
1001.521C	Saint Mary's Hospital	Department of Social Services
1001.525C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.541C	Saint Mary's Hospital	Waterbury Department of Education
1001.54C	Saint Mary's Hospital	3M Health Care Service Center
1001.590C	Saint Mary's Hospital	bioMerieux, Inc.
1001.592C	Saint Mary's Hospital	American National Red Cross
1001.603C	Saint Mary's Hospital	Unitex Textile Rental Services
1001.608C	Saint Mary's Hospital	City-Wide Delivery Service, Inc.
1001.632C	Saint Mary's Hospital	McKesson Health Solutions, LLC
1001.633E	Saint Mary's Hospital	Otis Elevator Company
1001.653C	Saint Mary's Hospital	Siemens Industry, Inc.
1001.668C	Saint Mary's Hospital	Yale University School of Medicine
1001.676E	Saint Mary's Hospital	SkillSurvey
1001.679C	Saint Mary's Hospital	3M Health Care Service Center
1001.681C	Heart Center of Greater Waterbury	University of Connecticut Health Center Department of Finance
1001.682C	Saint Mary's Hospital	Med3000, Inc.
1001.688C	Saint Mary's Hospital	Yale University School of Medicine
1001.691C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.694C	Saint Mary's Hospital	Healthstream, Inc.
1001.749C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.750C	Saint Mary's Hospital	Connecticut Light and Power Company
1001.768C	Saint Mary's Health System	Axiom Group, LLC
1001.783C	Saint Mary's Hospital	Best Practices, Inc.
1001.786C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.787E	Saint Mary's Hospital	GE Medical Systems
1001.788C	Saint Mary's Hospital	Financial Health Strategies, Inc.
1001.811C	Saint Mary's Hospital	Department of Public Health
1001.814C	Saint Mary's Hospital	Executive Health Resources, Inc. (E.H.R.)
1001.820E	Saint Mary's Hospital	Dell
1001.8221C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.825E	Saint Mary's Hospital	Diagnostic Equipment Service Corporation (DESCO)
1001.829C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.840C	Saint Mary's Hospital	University of Connecticut School of Allied Health

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.852C	Saint Mary's Hospital	Bay State Anesthesia
1001.853C	Saint Mary's Hospital	Department of Public Health
1001.858C	Saint Mary's Hospital	Anthelio Healthcare Solutions, Inc.
1001.860C	Saint Mary's Hospital	Syntrac Cardinal Health
1001.861C	Saint Mary's Hospital	Sunquest Information Systems, Inc.
1001.866C	Saint Mary's Health System	VPNE Parking Solutions, LLC
1001.882C	Saint Mary's Hospital	Naugatuck Valley Community College
1001.884C	Saint Mary's Hospital	Olympus America, Inc.
1001.886C	Saint Mary's Hospital	Telephone Nurse Triage - Kanagaratnam Jegathesan, MD
1001.890E	Saint Mary's Hospital	Corepoint
1001.891C	Saint Mary's Hospital	Advantage RN
1001.944C	Saint Mary's Hospital	RelayHealth
1001.950C	Saint Mary's Hospital	Xtend Healthcare, LLC
1001.962C	Saint Mary's Hospital	Precyse Solutions, LLC
1001.979C	Saint Mary's Hospital	Yale University School of Medicine
1001.997C	Saint Mary's Health System, Inc.	McKesson Corporation
1002.1048C	Franklin Medical Group, P.C.	Nuance Communications, Inc.
1002.1090C	Franklin Medical Group, P.C.	Digestive Disease Center of CT, LLC
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1002.448C	Franklin Medical Group, P.C.	Department of Public Health
1002.530C	Franklin Medical Group, P.C.	Napiello, Virginia APRN
1002.888E	Franklin Medical Group, P.C.	Phoenix Internal Medicine Associates, LLC
1002.958C	Franklin Medical Group, P.C.	VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc.
1002.959C	Franklin Medical Group, P.C.	Thames Records Management
1002.967C	Franklin Medical Group, P.C.	City-Wide Delivery Service, Inc.
1002.974C	Franklin Medical Group, P.C.	Intuitive Surgical, Inc.
1010.966C	Saint Mary's Hospital	Healogics Wound Care & Hyperbaric Services, Inc.
1010.968C	Saint Mary's Hospital	Commerce Bank
1010.978C	Saint Mary's Hospital	Central Connecticut State University
1010.985C	Saint Mary's Hospital	Jackson & Coker Permanent, LLC

NON-PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.445C	Saint Mary's Hospital, Inc.	Union Square Southbury, LLC (Landlord)
2005.445C	Saint Mary's Hospital, Inc.	Associated Physicians of Southbury, P.C. (Subtenant)
2005.762C	Saint Mary's Hospital, Inc.	146 Highland Associates, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc.	1981 East Main Street, LLC (Landlord)
2005.934E	Saint Mary's Hospital, Inc. (Sublandlord)	Inwelligent Healthcare, Inc. (Subtenant)
2007.104C	Saint Mary's Hospital, Inc.	Scovill Commons Partners, LLC (Landlord)
2007.1186E	Saint Mary's Hospital, Inc.	Subway Real Estate Corp. (Tenant)
2007.1227C	Saint Mary's Hospital, Inc.	Northwest CT Public Safety Communications Center Inc. (Tenant)
2007.245C	Saint Mary's Hospital Corporation	Spectrum Square, LLC (Landlord)
2007.273E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.285E	Saint Mary's Hospital, Inc.	Fraydun Enterprises, LLC (Landlord)
2007.509E	Saint Mary's Hospital Corporation	Scovill Commons Partners, LLC (Landlord)
2007.760C	Saint Mary's Hospital	JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord)
2007.761C	Saint Mary's Hospital	Park West, LLC (Landlord)
2007.765E APPRAISAL/OPINION - NOT REVIEWED	N/A	N/A
2013.1129C	Franklin Medical Group, P.C.	1177, LLC (Landlord)

PROVIDER CONTRACTS

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.1072C	Saint Mary's Hospital	Singanamala, Santhi MD
1001.1082C	Saint Mary's Hospital	Waterbury Pulmonary Associates, LLC
1001.1105C	Saint Mary's Hospital	Brittny Williams Howell, MD
1001.110C	Saint Mary's Hospital	Martinucci, Erica MD
1001.1176C	Saint Mary's Physician Partners, LLC	
1001.1216C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.1298C	Saint Mary's Hospital	Connecticut Children's Specialty Group, Inc.
1001.323E	Saint Mary's Hospital	Connecticut Children's Medical Center
1001.342C	Saint Mary's Hospital	Consultants In Pathology, PC
1001.37C	Saint Mary's Hospital	Rho, Mira MD
1001.39C	Saint Mary's Hospital	Roer, David MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1001.407C	Saint Mary's Hospital	Neurosurgery Orthopaedics & Spine Specialists PC
1001.783E	Saint Mary's Hospital	EmCare, Inc. AND EmCare, Inc.
1001.480C	Saint Mary's Hospital	Milford Anesthesia Associates, LLC
1001.543E	Saint Mary's Hospital	Koteles, Alicia MD
1001.547C	Saint Mary's Hospital	Raissi, Sina MD
1001.570C	Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership)	SurgiCenter Anesthesiologists, PC
1001.580C	Saint Mary's Hospital	Mayo Medical Laboratories
1001.593C	Saint Mary's Hospital	Zarif, Abdul MD
1001.68C	Saint Mary's Hospital	Zarif, Abdulmasih MD
1001.764C	Saint Mary's Hospital	Naugatuck Valley Women's Health Specialists, PC
1001.988E	Saint Mary's Hospital	Wellmore Behavioral Health
1002.1020C	Franklin Medical Group, P.C.	Monzurul Chowdhury, MD
1002.1031C	Franklin Medical Group, P.C.	Bechoi Saleib, MD
1002.1037C	Franklin Medical Group, P.C.	Anna Freitag, MD
1002.1051C	Franklin Medical Group, P.C.	Frank Longo, MD
1002.1067C	Franklin Medical Group, P.C.	Ken Matsuo
1002.1069C	Franklin Medical Group, P.C.	Joseph Bowen, MD
1002.1101C	Franklin Medical Group, P.C.	Marano, Albert
1002.1102C	Franklin Medical Group, P.C.	Lyall, Bhupinder
1002.1103C	Franklin Medical Group, P.C.	Feinberg, Michael
1002.1104C	Franklin Medical Group, P.C.	Kraus, Mark, MD
1002.1107C	Franklin Medical Group, P.C.	Anupama Paranandi, MD Infectious Disease
1002.1109C	Franklin Medical Group, P.C.	Sallie Carrington, DO
1002.1110C	Franklin Medical Group, P.C.	Preissler, MD Paul
1002.1112C	Franklin Medical Group, P.C.	Garsten, MD Joel
1002.1113C	Franklin Medical Group, P.C.	Burlison, MD Kathleen
1002.1117C	Franklin Medical Group, P.C.	Cohen, Matthew, MD
1002.113C	Franklin Medical Group, P.C.	Palesty, J Alexander MD
1002.116C	Franklin Medical Group, P.C.	Wetmore, Robert S MD, PC
1002.117C	Franklin Medical Group, P.C.	Sieling, Beth Ann MD
1002.118C	Franklin Medical Group, P.C.	Sookhan, Nicole MD
1002.11C	Franklin Medical Group, P.C.	Rosenhein, Brian DO
1002.1208C	Franklin Medical Group, P.C.	Giacomazzi, Peter, MD
1002.120C	Franklin Medical Group, P.C.	Galal, Magdy MD
1002.1238C	Franklin Medical Group, P.C.	Shetty, MD Shohan
1002.1242C	Franklin Medical Group, P.C.	Neamtu, MD Andreea

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.1268C	Franklin Medical Group, P.C.	Gork MD, Ahmet
1002.1269C	Franklin Medical Group, P.C.	Khan MD, Tasneem
1002.1270C	Franklin Medical Group, P.C.	Salerno MD, John
1002.1271C	Franklin Medical Group, P.C.	Polokoff MD, Ellen
1002.1272C	Franklin Medical Group, P.C.	Leal MD, Daniel
1002.1277C	Franklin Medical Group, P.C.	Medrano MD, Consuelito
1002.1278C	Franklin Medical Group, P.C.	Esemuede MD, Iyare
1002.1281C	Franklin Medical Group, P.C.	Thiruvengadam MD, Sudha
1002.12C	Franklin Medical Group, P.C.	Sheikh, Abdul Majeed MD
1002.1300C	Franklin Medical Group, P.C.	Carolyn O'Connor, MD
1002.1303C	Franklin Medical Group, P.C.	Greco, Thomas MD
1002.1304C	Franklin Medical Group, P.C.	Ann Marie Conti-Kelly, MD
1002.15C	Franklin Medical Group, P.C.	Te, Victorio Go MD
1002.18E	Franklin Medical Group, P.C.	Simms, Michael F MD
1002.20C	Franklin Medical Group, P.C.	Imam, Azhar MD
1002.22C	Franklin Medical Group, P.C.	Nawaz, Shah MD
1002.23C	Franklin Medical Group, P.C.	Alston, Shawnette MD
1002.25C	Franklin Medical Group, P.C.	Beri, Rohit MD
1002.26C	Franklin Medical Group, P.C.	Bogursky, Sondra MD
1002.299C	Franklin Medical Group, P.C.	Anthony, J Robert MD
1002.29C	Franklin Medical Group, P.C.	Colodner, Gregory MD
1002.34C	Franklin Medical Group, P.C.	Newell, Rebecca O MD
1002.36C	Franklin Medical Group, P.C.	Ouellette, Jason MD
1002.379C	Franklin Medical Group, P.C.	Chere, Mitch MD
1002.3C	Franklin Medical Group, P.C.	Ramos, Rey MD
1002.41C	Franklin Medical Group, P.C.	Talwalkar, Jaideep MD
1002.42C	Franklin Medical Group, P.C.	Vaezy, Ali MD
1002.432C	Franklin Medical Group, P.C.	Ndiaye, Mouhamed A MD
1002.457C	Franklin Medical Group, P.C.	Gega, Arjet MD
1002.493C	Franklin Medical Group, P.C.	Kelly, Paul MD
1002.501C	Franklin Medical Group, P.C.	Zhang, He MD
1002.503C	Franklin Medical Group, P.C.	Baba, Carolina Borz MD
1002.508C	Franklin Medical Group, P.C.	Rubenstein, Stephen MD
1002.513C	Franklin Medical Group, P.C.	Rovetto, Allyson MD
1002.515C	Franklin Medical Group, P.C.	Brenes, Laura C MD
1002.516C	Franklin Medical Group, P.C.	Zlotoff, Ronald A MD
1002.528C	Franklin Medical Group, P.C.	D'Souza, Bernard MD
1002.55C	Franklin Medical Group, P.C.	Almeida, Carlos MD

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
1002.569C	Franklin Medical Group, P.C.	Richi, Maysoun MD
1002.56C	Franklin Medical Group, P.C.	Alvarez, Alexander J MD
1002.58C	Franklin Medical Group, P.C.	Testa, John MD
1002.59C	Franklin Medical Group, P.C.	Uberti, James G MD
1002.614C	Franklin Medical Group, P.C.	Richi, Aziz MD
1002.655C	Franklin Medical Group, P.C.	Quinn, Edmund
1002.685C	Franklin Medical Group, P.C.	Karen Kennedy
1002.69C	Franklin Medical Group, P.C.	Cardiology Associates of Waterbury, PC
1002.756C	Franklin Medical Group, P.C.	Zefirova, Julia MD
1002.758C	Franklin Medical Group, P.C.	Cumberland, Melisha MD
1002.817C	Franklin Medical Group, P.C.	Mario Perez
1002.827E	Franklin Medical Group, P.C.	Seli, Meltem MD
1002.848C	Franklin Medical Group, P.C.	Albajrami, Oltjon MD
1002.879C	Franklin Medical Group, P.C.	Ranjan, Saurabh MD
1002.887C	Franklin Medical Group, P.C.	El-Hennawy, Magdy Sayed MD
1002.915C	Franklin Medical Group, P.C.	Philip R. Corvo, MD
1002.93C	Franklin Medical Group, P.C.	Naugatuck Valley OBGYN PC
1002.943C	Franklin Medical Group, P.C.	Maria Dawe, MD
1002.961C	Franklin Medical Group, P.C.	Macaron, Shady Hafez MD
1002.972C	Franklin Medical Group, P.C.	Naugatuck Valley Women's Health Specialists, PC
1002.993C	Franklin Medical Group, P.C.	Aditi Mukherji, MD
1002.995C	Franklin Medical Group, P.C.	Rebecca Scandrett, MD
1002.244C	Franklin Medical Group, P.C.	Naugatuck Valley OB-GYN Associates, PC
1001.266E	Saint Mary's Hospital	Connecticut Children's Medical Center

PROVIDER LEASES

CONTRACT NO.	SAINT MARY'S ENTITY	VENDOR / PROVIDER / NON-PROVIDER
2005.364C	Saint Mary's Hospital	Saint Mary's Hospital
2007.1285C	Saint Mary's Hospital	LJL Properties, LLC
2007.296C	Saint Mary's Hospital	West Main Medical, LLC, a Connecticut limited liability company, as Landlord
2008.534C	Primary Care Partners, P.C.	Greater Waterbury Primary Care Associates, P.C., as Tenant

Schedule 6.09(c)

Material Contracts - Validity

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

Schedule 6.10

Permitted Encumbrances

(1) Filing No. 0003104990 in favor of Wells Fargo Equipment Finance, Inc.

(2) Filing No. 0003013154 in favor of General Electric

Schedule 6.11

Condition and Sufficiency of the Saint Mary's Assets

No updates.

Schedule 6.12(a)

Owned Real Property

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

Schedule 6.12(b)

Leased Real Property

1. The property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, and which was subject to the lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006, as modified by the Lease Modification Agreement, dated January 1, 2009, is now owned by Saint Mary's Hospital, Inc.

Schedule 6.14(a)

Legal Proceedings

The following matters disclosed in the initial Disclosure Schedules have all been settled:

Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.
Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.

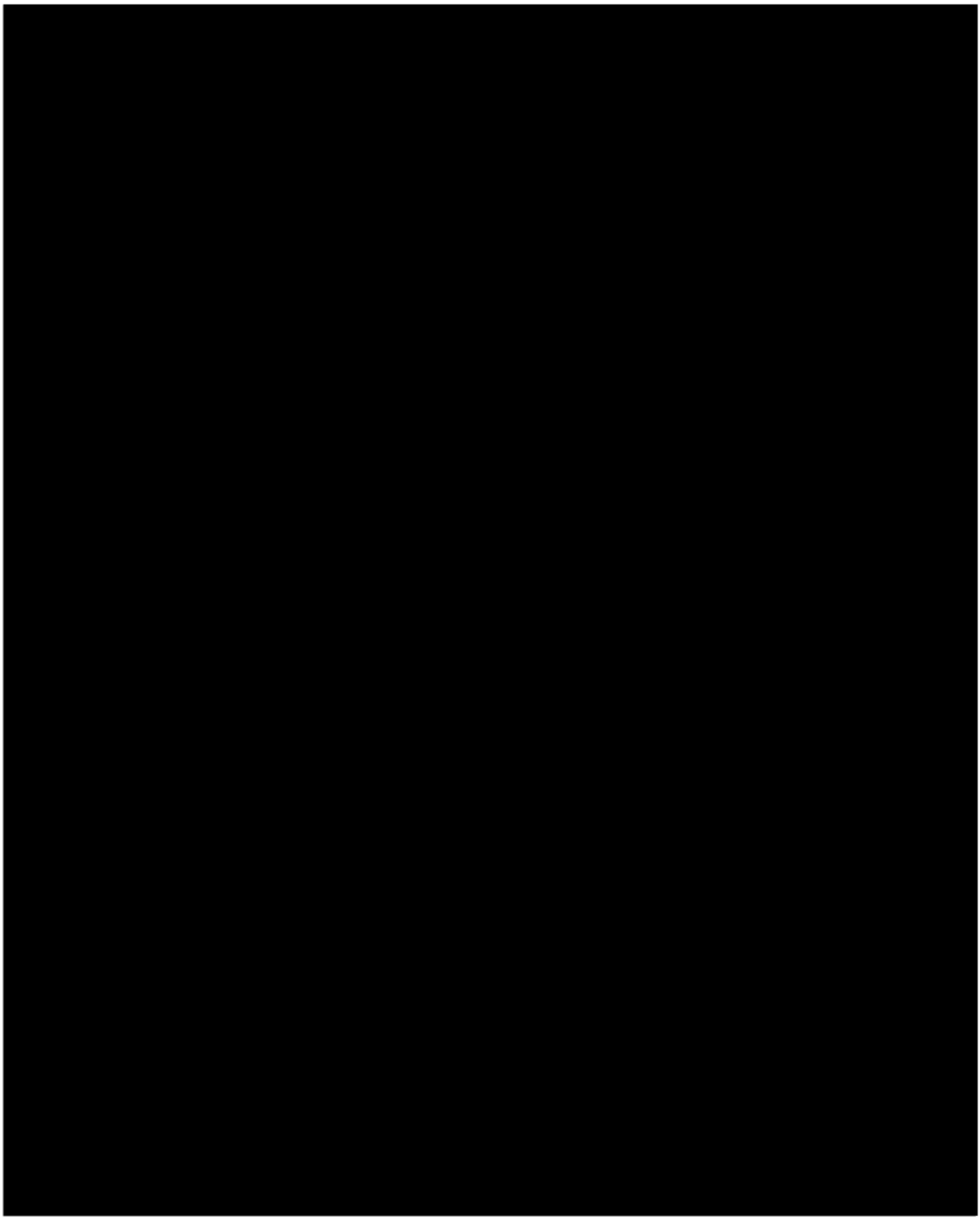
Schedule 6.14(b)

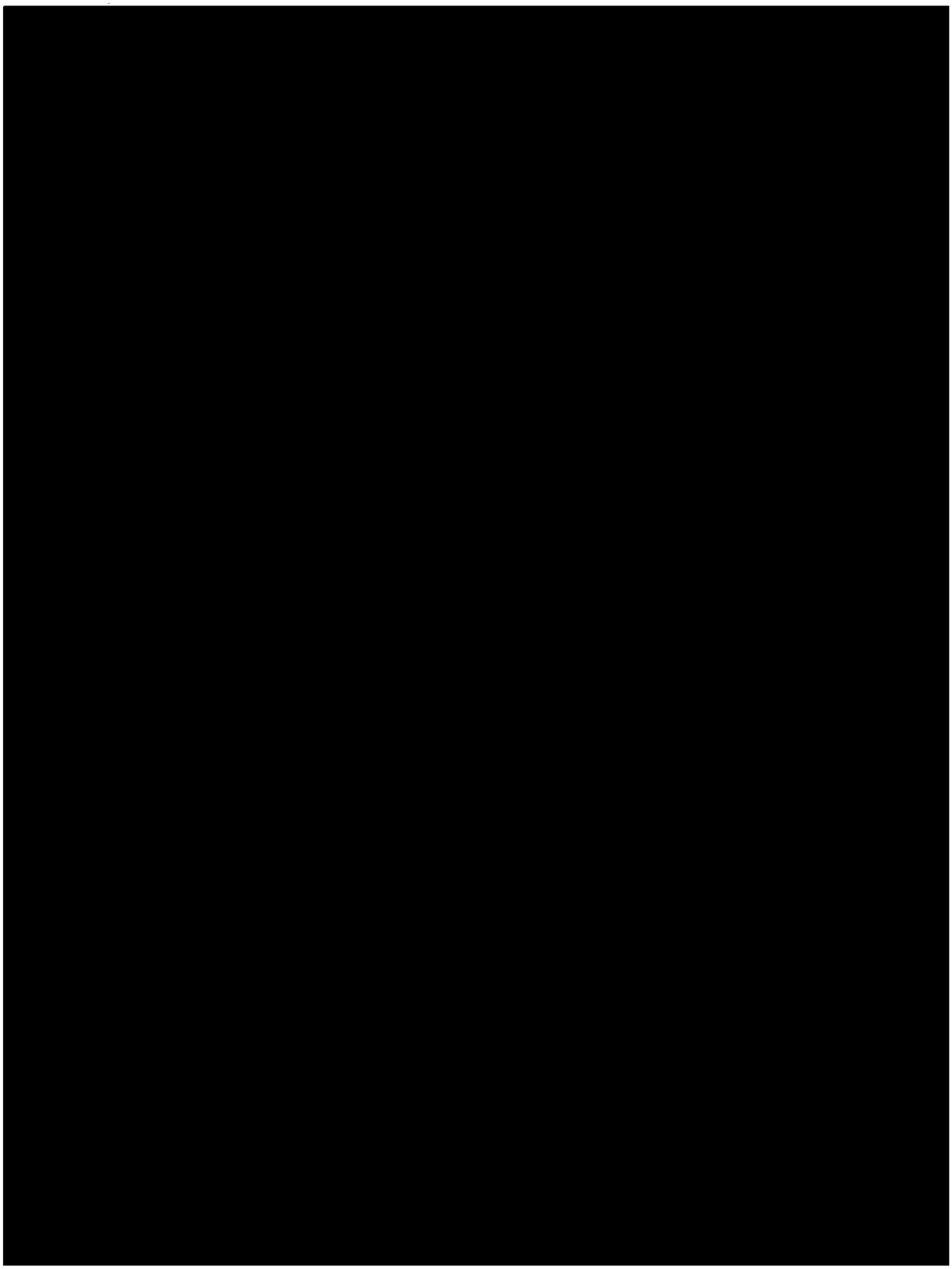
Governmental Orders

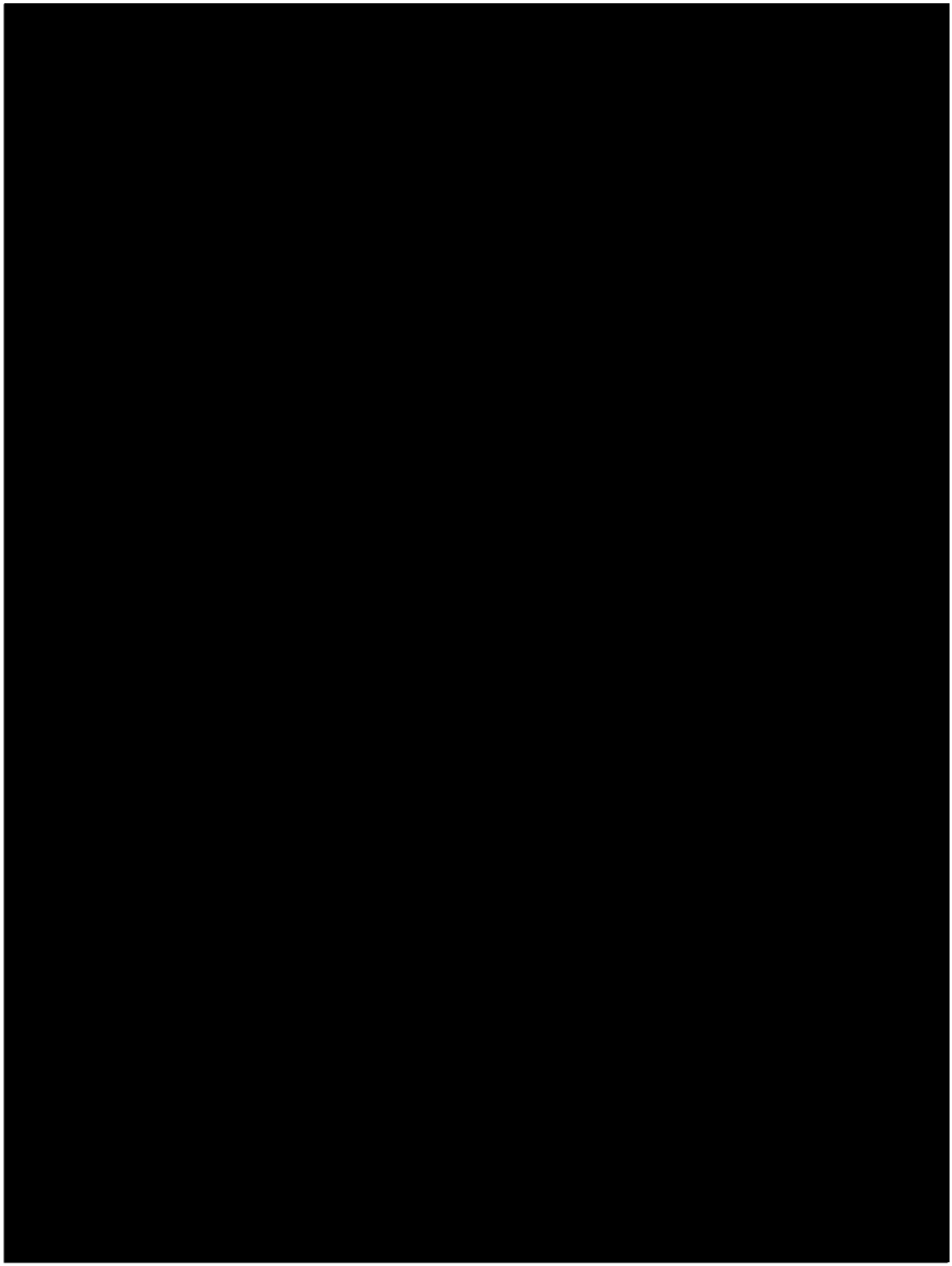
No updates.

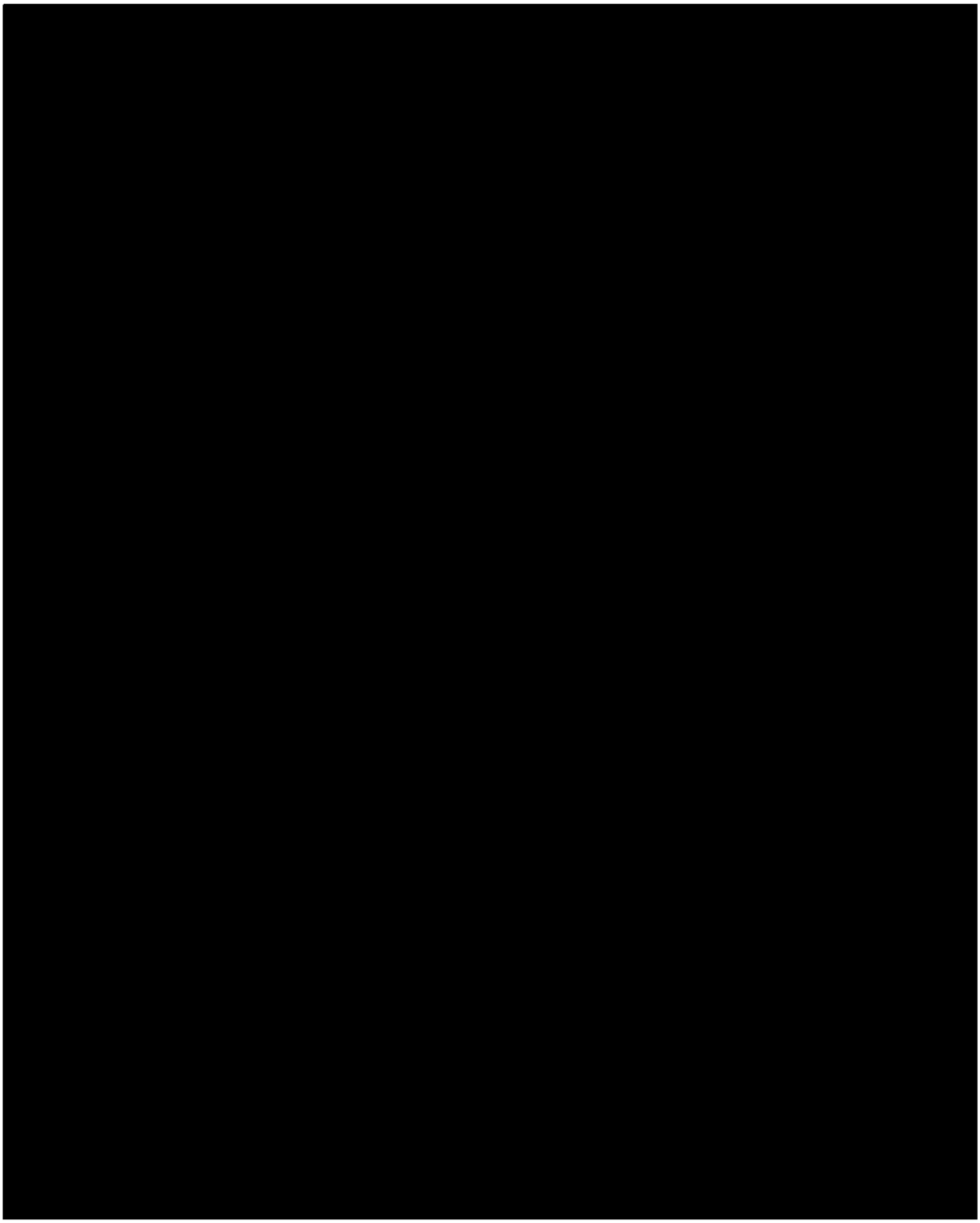
Schedule 6.15(a)

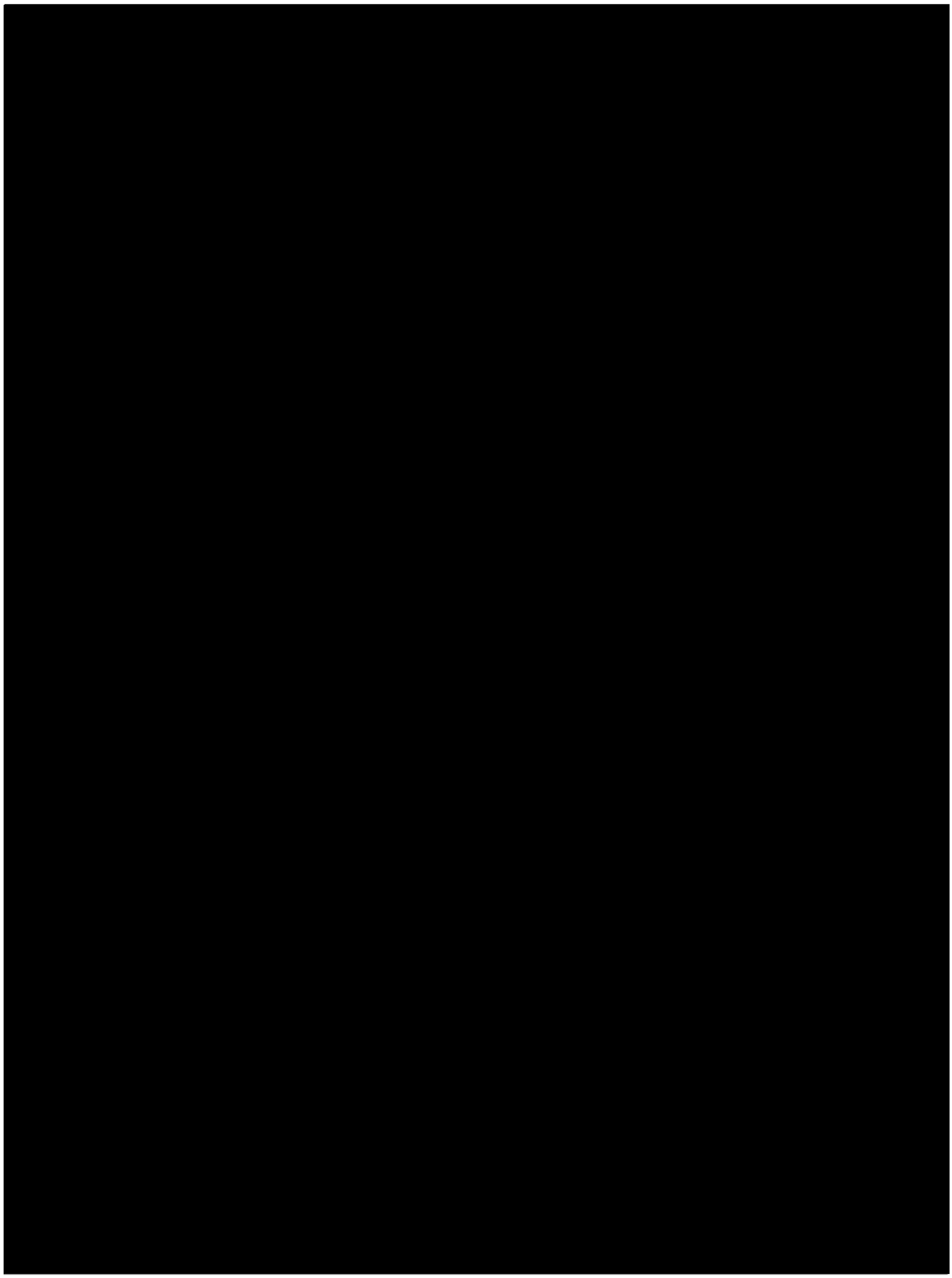
Compliance with Laws

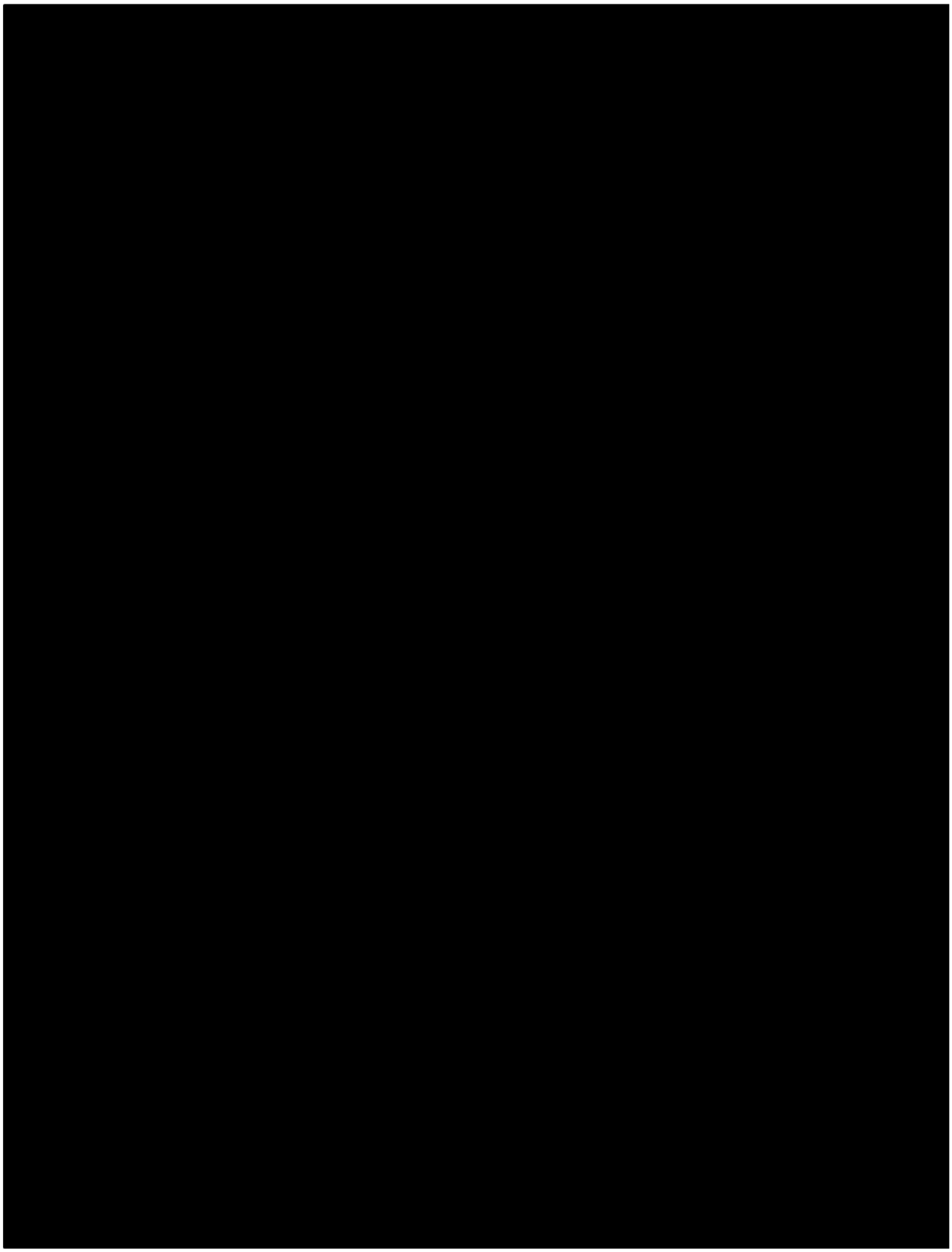


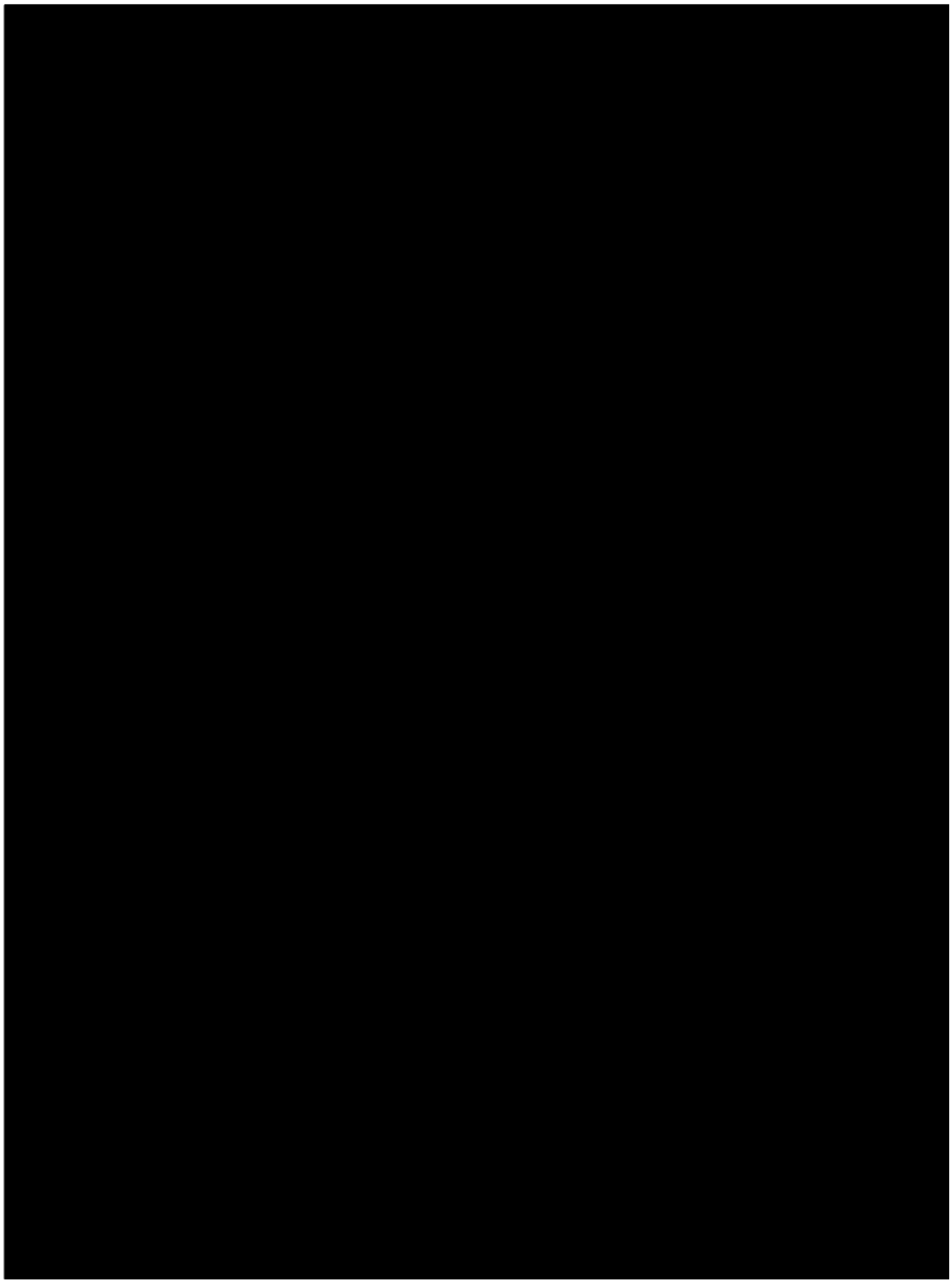


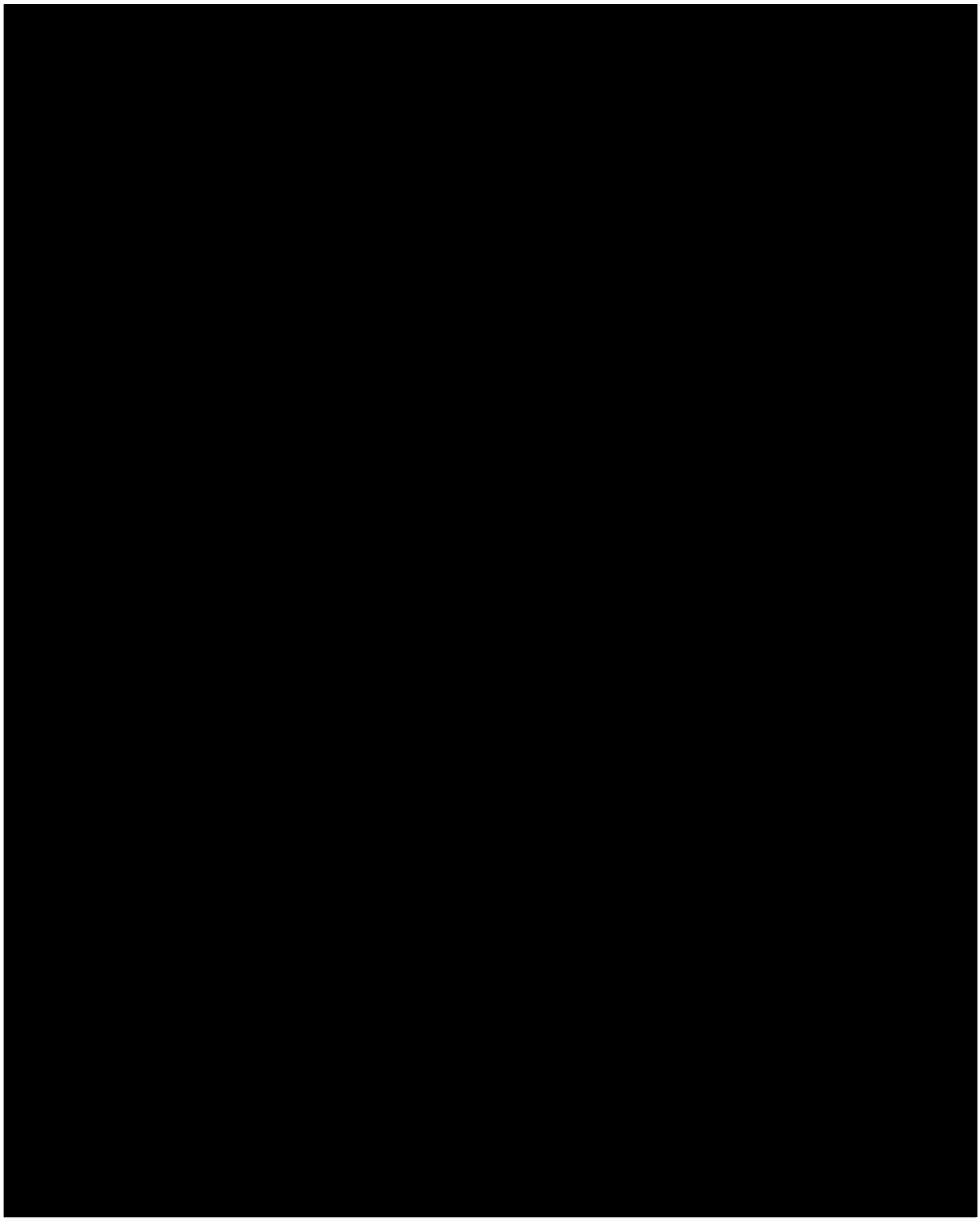


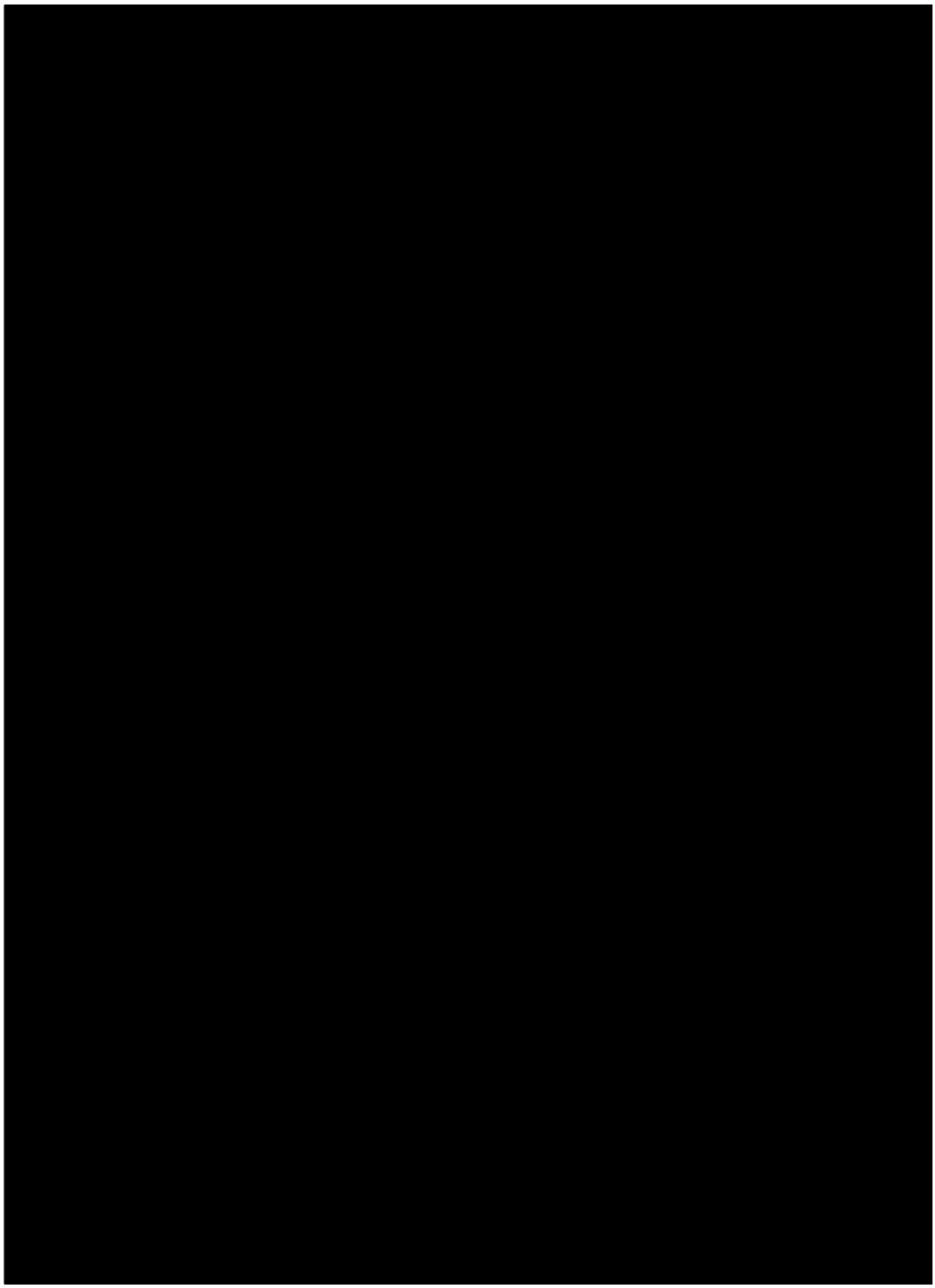


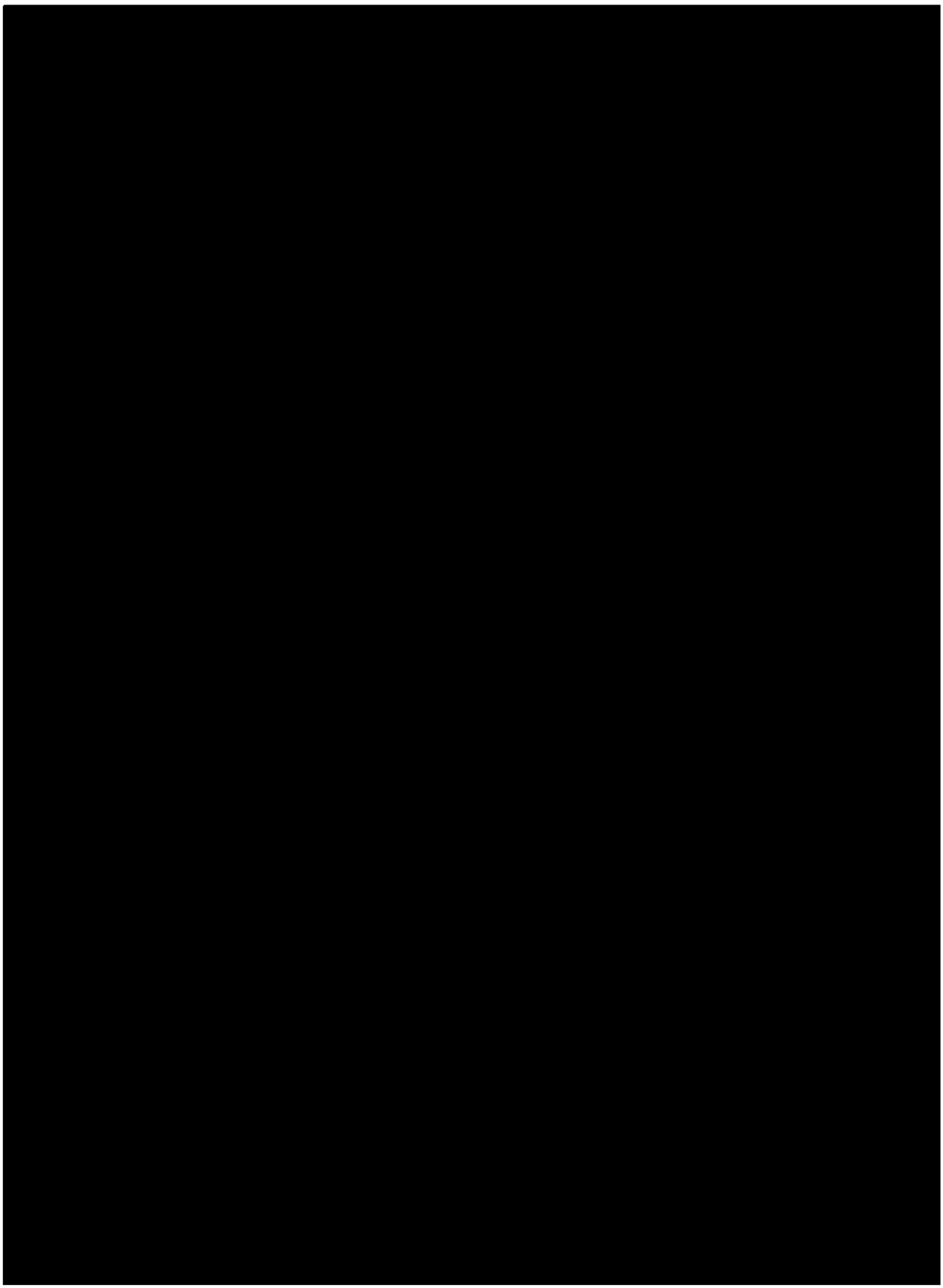












Schedule 6.16(a)

Medicare - Plans of Correction

No updates.

Schedule 6.16(b)

Medicare - Claims

- As of June 22, 2016, 454 Medicaid accounts were rebilled based on observation claims billed in excess of 24 hours. The total amount rebilled was $757,907.32. Notice of rebilling was placed in affected patient accounts. This matter is now closed.

- November 24, 2015 - Letter received from the State of Connecticut, Department of Social Services Office of Quality Assurance – Audit Division - Draft Results from FMG audit. A draft report was received covering DSS's audit of Medicaid claims paid to Franklin Medical Group during the period January 1, 2011 through December 31, 2013. The total of the proposed audit disallowances was $1,784,454. Additional documentation was provided and an exit interview was held. The final report was received on April 22, 2016. The overpayment due to DSS is $1,224,182. An appeal letter has been sent requesting a hearing.

Schedule 6.16(d)

Medicare - Accreditation Surveys/Deficiency Lists

No updates.

Schedule 6.19

HIPAA - Breach Notifications

- **February 10, 2016** - Saint Mary's reported a breach affecting approximately 33 individuals. On December 3, 2015, a contracted courier picked up a locked, secured bag containing 33 medical records from an outpatient center to bring to the hospital. During an intermediate stop, the courier's car, along with the bag containing the records, was stolen. The vehicle was recovered on December 7, 2015 but the records were not in the vehicle and were not recorded. Affected individuals were notified starting on December 4, 2015

Schedule 6.20

Affiliate Transactions

No updates.

Schedule 6.21(e)

Environmental

The following environmental reports came into the possession of Saint Mary's subsequent to the Signing Date:

1. Limited Asbestos Inspection - Kenny Building, 1st Floor Rooms K1-101 & K1-105, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated September 30, 2015

2. Limited Asbestos Inspection - Lawlor Building, Second Floor, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated October 12, 2015

3. Limited Suspect Asbestos Inspection and Bulk Sampling - O'Brien Building, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated January 22, 2016

4. Fire Pump Performance Inspection Report, performed by Mack Fire Protection, dated June 30, 2015

5. Certified Test, Adjust and Balance Report, performed by Air Balancing Service Co., dated June 22, 2015

6. Medical Gas System Inspection & Safety Survey, performed by Praxair Healthcare Services, dated March 10, 2016.

Schedule 6.22

Employee Benefit Matters

6.22(a)

1. Management Time Off Policy
2. Accrued Time-Off Benefits
3. HSA Plan
4. High Deductible Plan
5. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015.
6. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.
7. Wellness Plan

To the knowledge of Saint Mary's, with the exception of plan documents relating to the HSA and High Deductible plans, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health. The plan documents relating to the HSA and High Deductible plans have not been prepared to date.

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(c)

No updates.

6.22(d)

No updates.

6.22(e)

No updates.

6.22(f)

Policy and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(g)

1. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015

2. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.

6.22(h)

No updates.

6.22(k)

No amendments have been made to non-competition and severance agreements for purposes of complying with Section 409A.

Schedule 6.23

Employment Matters

No updates.

Schedule 6.24

Taxes

No updates.

Schedule 6.25

Insurance

[6.25(i) requires a true and complete list of all current insurance policies - this is unchanged since signature date and thus no updates are required. 6.25(ii) requires a list of all pending claims and the claims history related to SMH for the 10 year period prior to Signature Date and thus does not need to be updated. However, an updated list of pending claims has been provided to NE-RHM and Trinity Health.]

Schedule 7.04

Conflicts - Trinity Health and NE-RHM

No updates.

Schedule 7.08(a)

Compliance with Laws - NE-RHM

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC has appealed the Medicaid findings.

On June 29, 2016 Saint Francis Medical Group ("SFMG") concluded a retrospective review of claims billed to NGS, Medicare Administrative Contractor. SFMG determined that some of the critical care E&M services should have been billed as E&M subsequent care services. The result of the findings is that a refund is required for reimbursement received by SFMG for Inpatient Critical Care services that were not billed according to CMS instructions. These findings were first identified through an operational review in an attempt to identify possible opportunities for operational improvement as a part of SFHMC and SFMG's Integrity and Compliance Program ("ICP"). SFMG put corrective actions in place. The refund to the Medicare Program as a result of this review is $281,740 for the payments received as a result of the error in submitting E&M critical care when it should have been submitted as E&M subsequent care services to NGS Medicare for payment. Due to the time elapsed and the inability to file a corrected claim, SFMG returned the overpayment to Medicare for the aforementioned errors. SFMG is in the process of refunding $101,990 to the Medicaid program as a result of this review.

On May 18, 2016 SFHMC and SFMG received a civil investigative demand subpoena from the U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations, issued pursuant to the authority provided to the Inspector General under Public Law 95-452 in regards to services rendered by licensed independent practitioners. This is in document gathering phases at this time.

Schedule 7.09(a)

Medicare - Plans of Correction - NE-RHM

In addition to those matters originally set forth on Schedule 7.09(a) to the Transfer Agreement on the Signing Date:

The Department of Public Health conducted a Complaints; Adverse Events and CMS follow up survey beginning June 13, 2016. The Department of Public Health has not yet released any findings.

Schedule 7.09(b)

Medicare/Medicaid Claims - NE-RHM

No non-routine Medicare appeals

Saint Francis Hospital and Medical Center has several Inpatient and Outpatient Medicaid rate appeals and requests for hearings, with the first rate hearing scheduled for the fall of 2016.

Additionally, SFHMC has Department of Social Services and Department of Revenue Service Petitions for Declaratory Ruling on the Hospital Tax.

Schedule 7.12

HIPAA - Breach Notifications - NE-RHM

YEAR	Date of Occurrence	Title	Action
Reported to OCR 2/2015	10/24/2014	Inappropriate Access to PHI	Employee termination: Obtained information to locate ex-husband by looking at the record for his current significant other.
	9/23/2014	Stolen Laptop	Employee counseled: Medical Necessity Documentation saved to home computer in an effort to catch up on paperwork
	12/31/2013	Stolen ED Log	Employee counseled: Report to OCR January, 2014
Reported to OCR 2/2016	4/8/2015	USPS Damaged Package	Patient notified. Envelopes for mailing will be mylar.
	7/17/2015	Pulmonary office staff mailed lab results for several patients to one patient	Employee counselled and office staff re-educated
	10/26/2015	Adoptive/Birth Mother Demographics	Epic build to prevent sharing of demographic information between baby and birth mother.

Schedule 8.08(a)

Insured Real Property

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, October 28, 2016 12:17 PM
To: User, OHCA
Cc: Anthony, Robert J.
Subject: Submission for Condition #4 - 15-32045-CON Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England
Attachments: SMHCHNA_2016.pdf

Hello,

Per Condition # 4 of the Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England, ***Docket #: 15-32045-CON***, attached is the recently completed 2016 Community Health Needs Assessment (CHNA). A copy of the CHNA is publically available on the Saint Mary's website at https://www.stmh.org/about/chna/. The Implementation Strategy is currently in development and will be submitted once completed.

Feel free to contact me with any questions.

Regards,

Claudio A. Capone, FACHE
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

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Saint Mary's Hospital
Community Health Needs Assessment

Saint Mary's
HOSPITAL
Exceptional care. Every patient. Every day.

Note: Approved and adopted by the Saint Mary's Hospital Board of Directors September 1, 2016

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Executive Summary

In collaboration with the Greater Waterbury Health Improvement Partnership, Saint Mary's Hospital led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2016. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This Community Health Needs Assessment serves as a compilation of the overall findings of each research component.

CHNA Data Components

- DataHaven Community Wellbeing Survey (2015)
- Healthy People 2020 Report (2014)
- The ALICE study of Financial Hardship Report (2012)
- US Center for Disease Control and Prevention
    - County Health Rankings and Roadmaps (2016)
- Saint Mary's Hospital Community Health Profile (2015)
- Hospital Implementation Plans (2013)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Obesity
- Tobacco Use
- Asthma
- Health Communications

Documentation

The final report of the CHNA was made public on September 30, 2016 and can be found on the Saint Mary's Hospital website (stmh.org). Paper copies are also available per request. The Saint Mary's Hospital Board of Directors approved the CHNA on September 1, 2016. An implementation plan for community health improvement activities will be created and available by February 15, 2017.

Introduction

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 2,100 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2016, Saint Mary's Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with The Greater Waterbury Health Improvement Partnership. The partnership consists of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Saint Mary's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs.

Community Health Needs Assessment Summary

Community Health Needs Assessments (CHNA) and implementation strategies are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. The CHNA and implementation strategies create an important opportunity to improve the health of communities by ensuring that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health.

Saint Mary's Hospital published its first federal mandated CHNA in 2013 in collaboration with contracted research and consulting firm, Holleran, and The Greater Waterbury Health Improvement Partnership. The 2016 assessment will serve as a starting point for data-based goals and strategies on how to address the needs that have been identified. The health needs acknowledged by the CHNA will be integrated into a three-year community outreach plan and implementation strategy to overcome the issues. By utilizing existing resources, strengthening partnerships and creating innovative programs on both the hospital campus and within the community, Saint Mary's Hospital hopes to make a positive impact on these identified needs.

Report on Progress since 2013 CHNA

Saint Mary's has made meaningful progress during this three-year CHNA cycle as we have opened two new urgent care centers and grown our primary care practices with over twenty new internal medicine providers. Saint Mary's now offers four urgent care centers throughout our service area offering convenient access and extended hours. We continue to offer nurse navigation services for emergency department patients, and for our cardiac program to provide education and coordinate post-acute services. We established the "Pump Club" for cardiac patients who needed additional services to attend rehab sessions and other services. Saint Mary's also established a heart rhythm program during this period, creating easier, local access to electrophysiology services that were previously not available in our community. Saint Mary's continues to support and collaborate with the Malta House of Care, which provides medical services to undocumented and indigent population. We continue to work closely with the Harold Leever Cancer Center to address smoking cessation in our community. We have hosted a series of farmers markets on the hospital campus using our community partner, Brass City Harvest. Through our work with the Greater Waterbury Health Improvement Partnership are working towards the creation of a Community Care Team to provide cross-organization case management for high utilization emergency department visitors.

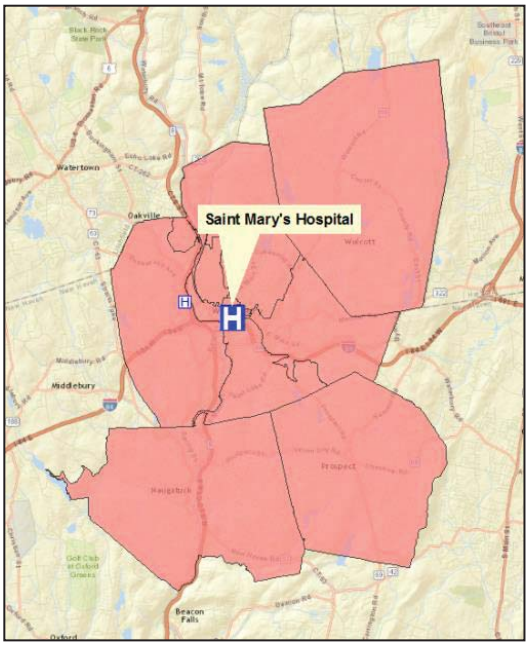
Since 2013 Saint Mary's has continued to work towards maintaining its existing programs while introducing new initiatives as appropriate. We have also continued to fully participate in the Greater Waterbury Health Improvement Partnership (GWHIP) which creates opportunities for collective impact, fosters greater collaboration community-wide, and helps make better use of resources by eliminating duplication of effort wherever possible. In August 2016 Saint Mary's joined Trinity Health, becoming a part of the Trinity Health – New England regional health ministry. Becoming part of a strong national and regional system will provide further opportunities to enhance our ability to meet the needs of our community.

Overview of Hospital Service Area and Facilities

Service Area

Saint Mary's total service area is comprised of 35 zip codes, which include the city of Waterbury and 17 surrounding towns. The primary service area which covers 9 US Census zip code tabulation areas (ZCTAs) includes Waterbury, Naugatuck, Prospect and Wolcott has a population of approximately 168,000. The secondary service area includes Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plantsville, Plymouth, Southbury, Thomaston, Watertown and Woodbury has a population of approximately 153,000.

Figure 1. Saint Mary's Primary Service Area Map



2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Population

The combined population for these communities is roughly 321,000 residents where the majority of Saint Mary's hospital patients live in the city of Waterbury which is particularly economically distressed. The median household income is $41,136, which is significantly less than the overall service area, which is approximately $70,000. The unemployment rate in the city of Waterbury in September 2015 was 10.7%. This is higher than the state of Connecticut unemployment rate of 6.6%. Approximately 31.6% of the population in Waterbury speaks a language other than English in the home. This is higher than the state of Connecticut where 20.8% of the population speaks a language other than English in the home. In addition, 24.2% of families in Waterbury have poverty status compared to 10.5% in Connecticut.

Central Waterbury has been designated a Medically Underserved Area (MUA) and Medically Underserved Population (MUP) by the health resources and services administration (HRSA). HRSA has also designated central Waterbury as a Health Professional Shortage Area (HPSA) for primary medical care, dental care and mental health. In Table 1. CHA Service Area Population Findings, there is a breakdown of population details provided by the US Census (2009-2013) and specifically the Primary Service Area of Saint Mary's Hospital.

Table 1. CHA Service Area Population Findings

Demographic Category	Indicator	Primary Service Area Total		Connecticut Total	
Total Population	Total Population	168,145	100%	3,583,561	100%
Age	Less than 18 Years Old	40,417	24%	802,718	22%
	Over 64 Years Old	22,263	13%	519,616	15%
Race and Ethnicity	White	96,590	57%	2,526,401	70%
	Black	21,484	13%	337,758	9%
	Hispanic	42,329	25%	496,393	14%
	Asian	3,124	2%	140,592	4%
	Other	4,618	3%	81,871	2%
Gender	Male	81,194	48%	1,745,194	49%
	Female	86,951	52%	1,838,367	51%

Source: US Census (2009-2013) and primary service area determined by Connecticut Hospital Association (2015)

Saint Mary's Facilities

Saint Mary's Hospital

Saint Mary's Hospital is a Catholic, not-for-profit, community teaching hospital that has been serving patients in Waterbury, Connecticut since 1909. The hospital offers a wide variety of medical services, educational classes, and patient resources in addition to a Level II Trauma Center, pediatric emergency room, award winning cardiac and stroke care and exceptional surgical services.

Naugatuck Valley Surgical Center

Naugatuck Valley Surgical Center (NVSC) is an outpatient department of Saint Mary's Hospital which offers state-of-the-art operating rooms and post-operative patient care areas for ambulatory surgery. The surgical center staff is experience in a wide variety of specialties including Gastroenterology, General Surgery, Gynecology, Ophthalmology, Oral/Dental Surgery, Orthopedics , Otorhinolaryngology (ENT), Pain Management, Plastic Surgery, Podiatry and Urology

The Harold Leever Regional Cancer Center and Saint Mary's Hospital Oncology Center

The Harold Leever Regional Cancer Center is a joint partnership of Saint Mary's Hospital and Waterbury Hospital offering the highest quality care for cancer patients. In the building sits Saint Mary's Hospital Oncology Center which provides the most up-to-date treatment and protocols for patients right here in our community, and is located right in Waterbury, just off I-84.

Saint Mary's Medical Imaging Center

From X-rays, MRI and CT scans to images taken at a nuclear level, Saint Mary's is dedicated to providing advanced radiology services. Saint Mary's Medical Imaging Center is fully digital, which offers many advantages, including improved image quality and enhanced speed.

Saint Mary's Hospital Urgent Care Centers (Cheshire, Naugatuck, Wolcott, Waterbury)

Saint Mary's has expanded its footprint to offer four urgent care locations that provide a greater access to care for patients in the service area. The urgent care centers offer a wide array of services including x-ray, laboratory services, EKGs, immunizations and vaccines, pediatric care, and work-related injuries.

Community Health Needs Assessment Process

Saint Mary's Hospital's 2016 CHNA is based on data and input from multiple sources. These include:

- **DataHaven Health and Wellbeing survey**: Saint Mary's participated in this data collection effort through the Greater Waterbury Health Improvement Partnership. The survey was conducted statewide, providing a valuable data set across multiple communities. A separate report was developed focusing on the Waterbury community.
- **GWHIP Steering Committee Strategic Review**: the founding partners of the Greater Waterbury Health Improvement Partnership met to review our collective experience and insights from 2013-2016. We discussed the performance of the various workgroups, initiatives implemented, and the expected impact. Based on this assessment several changes were recommended.
- **CDC Learning Cohort**: Waterbury was one of thirteen communities in the country selected to participate in this learning opportunity**.** The learning cohort offered access to best practices, insight into what's worked in other communities, and specific coaching
- **Trinity Health Community Health & Well Being**: As Saint Mary's prepared to become a member of Trinity Health, we were afforded the opportunity to have discussions with colleagues from Hartford as well as the system office in Lavonia, Michigan. These discussions, although preliminary in nature, have begun to shape our planning process. We expect that we will gain further benefit as we move ahead once fully integrated in to the Trinity Health regional health ministry.

Each of these inputs contributed a unique perspective to the overall plan.
Additional inputs and resources are listed below.

Community Primary Data Sets
Community Programming Surveys
The data was gathered from information residents who attended Saint Mary's Hospital's community outreach programs specifically with the Spirit of Women Network. This came in the form of post-event surveys and verbal conversations.

Community Leader Discussions/Executive Meeting
In addition to gathering quantitative data, Saint Mary's obtained input from important community stakeholders regarding the health needs of the community. Interviews and informal discussions with community leaders in the Greater Waterbury area were also used to expand the knowledge of the issues affecting the service area. Some if not most of the community leaders that were involved in discussions grew up in the area and represented broad interests in our community including: leaders of medically underserved and low-income populations, persons with expertise or special knowledge in public health, and persons who lead local health agencies. In addition, a comprehensive community executive meeting was held in June 2016 and informal discussions with key informants in regards to Saint Mary's service area were completed.

Community Health Needs Assessment Data Sets
The following data sets were used and analyzed in order to obtain secondary data for Saint Mary's 2016 CHNA.

The ALICE Study of Financial Hardship Report
In 2012, the United Way completed a report titled ALICE (Asset Limited, Income Constrained, and Employed) which represented the growing number of individuals and families who are working, but are unable to afford the basic necessities such as housing, food, child care, health care, and transportation.

State of Connecticut
The official website of the State of Connecticut (ct.gov). Several resources were used from the State of Connecticut's website primarily regarding education and public health datasets for the purposes of expanding the information in this CHNA.

US Center for Disease Control and Prevention
As the leader in the nation's public health concerns, the US Center for Disease Control and Prevention (CDC) provides insights and data on diseases, chronic to acute and curable to preventable.

County Health Rankings and Roadmaps (2016)
These are the data measures adopted by the Centers for Disease Control (CDC) as standard measures of community health by which to assess the nation's health and allows comparisons at national, state and local levels. They have been selected based on their relevance as indices of community health and their general availability for assessments at all levels. The information for this data can be found in Appendix 1 and is often referred to in this CHNA.

Healthy People 2020 (2014)
Healthy People 2020 was developed by the Office of Disease Prevention and Health Promotion to assist in creating societies of residents living long and healthy lives and specifically offers state-by-state data.

Saint Mary's Hospital Community Health Profile (2015)
The Saint Mary's Hospital Community Health Profile (2015) was provided by the Connecticut Hospital Association(CHA). Completed each year by CHA, the document provides data and support for Connecticut hospitals and their community partners particularly with the Community Health Needs Assessment. Within this community profile, data was used from CHA's ChimeData database, US Census, the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS), the Connecticut Department of Public Health, and several other sources.

The 2015 DataHaven Community Health and Wellbeing Survey
The public service organization, DataHaven, completed the DataHaven Community Health and Wellbeing Survey in 2015 as a grassroots and locally based effort to promote regional well-being and quality of life. Using telephone surveys, the company was able to receive data from nearly 17,000 residents of Connecticut of which 610 were surveyed from the City of Waterbury. The information from the survey was heavily used in this CHNA and provided necessary information for prioritization for Saint Mary's.

Research Limitations
It should be noted that the availability of secondary data may represent some research limitations.

Community Health Needs Assessment Findings

Saint Mary's utilized the "Invest in Your Community: 4 Considerations to Improve Health and Wellbeing for All" and the "County Health Rankings Model - Health Factors" as guide and framework for its work. The Centers for Disease Control and Prevention (CDC) created a detailed outline which has been used as the core of the Greater Waterbury Health Improvement Partnership it can be found on page 24 of this CHNA.

Using the CDC's graphic as a model, Saint Mary's focused on the four elements of good health:

- Socioeconomic Factors, which accounts for 40%
- Physical Environment, which accounts for 10%
- Health Behaviors, which account for 30%
- Clinical Care, which accounts for 20%

Socioeconomic Factors

Socioeconomic factors have the largest impact on one's health according the CDC model of community health and wellbeing accounting for 40% in the described model. Socioeconomic factors that affect good health include a combination of: education, employment, income, and community support. These factors are known as the "social determinants" of health.

Employment & Income

According to the 2012 ALICE (Asset Limited Income Constrained Employment) Report, the state of Connecticut had a poverty rate of 10% and a median household income of $67,276. These numbers compare well to the U.S. average poverty rate of 15%, and the median household income in U.S. of $51,371. When looking specifically at the city of Waterbury, one of Connecticut's largest cities the report showed that out of 40,992 households, 23% of the residents were living in poverty and an added 34% fell under the ALICE characterization totaling over 50% of households below the ALICE threshold. Additional information can be seen in Table 2. in regards to the ALICE Report.

Table 2. Key Facts and ALICE Statistics by Municipality, Connecticut, 2012

Municipality	Waterbury, New Haven County
Population	109,915
Households	40,992
Poverty %	23%
ALICE %	34%
Above ALICE Threshold %	43%
Gini Coefficient	0.45
Unemployment Rate	13%
Health Insurance Coverage %	86%
Housing Burden: Owner over 30%	42%
Housing Burden: Renter over 30%	60%

Source: United Way ALICE Report; American Community Survey

Saint Mary's primary and secondary service area as mentioned above encompasses 35 zip codes and 17 towns. On page 11, The ALICE and Poverty Rates by Towns can be seen in Table 3 and include information with the total households and the total % of ALICE and Poverty households pertaining to the specific town.

Table 3. ALICE and Poverty Rates by Town, 2012

Town	Total Households	% ALICE and Poverty
Beacon Falls	2,244	26%
Bethlehem	1,409	17%
Cheshire	9,641	15%
Middlebury	2,797	20%
Morris	967	27%
Naugatuck	12,588	40%
Oxford	4,420	13%
Plymouth	4,739	24%
Prospect	3,280	19%
Southbury	8,022	31%
Thomaston	3,192	27%
Waterbury	40,992	57%
Watertown	8,270	25%
Wolcott	5,947	23%
Woodbury	4,204	24%

Source: United Way ALICE Report, U.S. Department of Housing and Urban Development (HUD), U.S. Department of Agriculture (USDA), Bureau of Labor Statistics (BLS), Internal Revenue Service (IRS) and state Treasury, and ChildCare Aware, 2012; American Community Survey, 1 year estimate.
*Note: Plantsville, Connecticut (zip code: 06479) was not included in the service areas reported

Education

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. According to the U.S. Census Bureau, High school and higher education graduation rates are lower in Waterbury (79.6% and 16.0% respectively) than in Connecticut (86.3% and 29.3% respectively).

According to the County Health Rankings in Saint Mary's service area counties the percentage of students who graduate High School in four years from New Haven County is 81%, from Litchfield County is 89%, and Hartford County is 82%. As seen below in Table 4. in Saint Mary's Service area covered by the Connecticut Hospital Association, 20% of the residents have a Bachelor's Degree or higher, whereas 36% of the State of Connecticut hold such education.

Table 4. Socioeconomic Data by CHA Primary Service Area

Demographic Category	Indicator	Primary Service Area Total		Connecticut Total	
Socioeconomics	Below Poverty	29,226	18%	354,348	10%
	Bachelor's Degree or Higher	22,198	20%	886,514	36%

Source: US Census (2009-2013); primary service area determined by Connecticut Hospital Association (2015)

In recent reports from the 2013-2014 Connecticut Department of Education Chronic Absenteeism Report, Waterbury Public Schools are on the top of the list for chronic absenteeism in the district. Over 20% of students in the district fall into the category of chronically absent from school which is defined as any student with a calculated Average Daily Attendance (ADA) of less than or equal to 90%. This number was significantly higher when looking at chronic absenteeism in the Waterbury Public High School rates which were at 33.7% among the highest in the state of Connecticut.

Neighborhood and Community Safety

One of the most significant social determinants of health is the conditions in which residents have a sense of security and community within their geographic location. In order to better understand overall safety in the community in three different levels, data was taken from overall Connecticut respondents, Greater Waterbury and Waterbury. Within that data table below, one can see that overall the results for satisfaction with Greater Waterbury was 78% and in the city of Waterbury was 63%.

Table 5. Neighborhood Satisfaction

Are you satisfied with the city or area where you live?

	Connecticut	Greater Waterbury	Waterbury
Yes	82%	78%	63%
No	17%	22%	36%
Don't Know	1%	1%	1%
Refused	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

While the overall satisfaction in Greater Waterbury and Waterbury are less than the Connecticut average ranking quite high at 82%, the responses for the safety of residents in their neighborhood merits further examination which can be seen below at staggering rates below the Connecticut's average.

Table 6. Residents Safety

The job done by the police to keep residents safe…

	Connecticut	Greater Waterbury	Waterbury
Excellent	30%	30%	15%
Good	45%	41%	35%
Fair	15%	16%	28%
Poor	6%	9%	16%
Don't know enough about it in order to say	4%	3%	5%
Refused	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Table 7. Neighborhood Responses

The information below portrays the percentage of respondents that stated that they "strongly agreed" with the specific questions asked in the DataHaven Health and Wellbeing Survey.

Questions answered with "Strongly Agree"	Connecticut	Greater Waterbury	Waterbury
There are safe sidewalks and crosswalks on most of the streets in my neighborhood.	39%	32%	39%
I do not feel safe to go on walks in my neighborhood at night.	16%	18%	29%
People in my neighborhood can be trusted.	54%	55%	33%
Children and youth in my town generally have the positive role models they need around here.	38%	38%	17%

Source: DataHaven Health and Wellbeing Survey

Transportation

Comparable to state average, the Greater Waterbury service area residents have access to a car or have their own car as the primary means of transportation as seen in Table 8. Public transportation is available in this city of Waterbury and immediate suburban towns but only 8% of respondents in the DataHaven survey said to use it. With a 12% response, most residents in Waterbury would be more apt to get a ride from a friend or relative than to use public transportation as a primary means of transportation.

Table 8. Access to Car

Do you have access to a car when you need it? Would you say you have access…

	Connecticut	Greater Waterbury	Waterbury
Very often	85%	83%	74%
Fairly often	4%	5%	4%
Sometimes	5%	5%	8%
Almost never	1%	1%	3%
Never at all	5%	6%	11%
Don't Know	0%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Physical Environment

According to the CDC model, where you live is one of the greatest predictors of how healthy you will be and accounts for 10% in the "Invest in Your Community" Model. Living in a safe neighborhood that has adequate environmental factors can lead to higher rates in overall wellbeing.

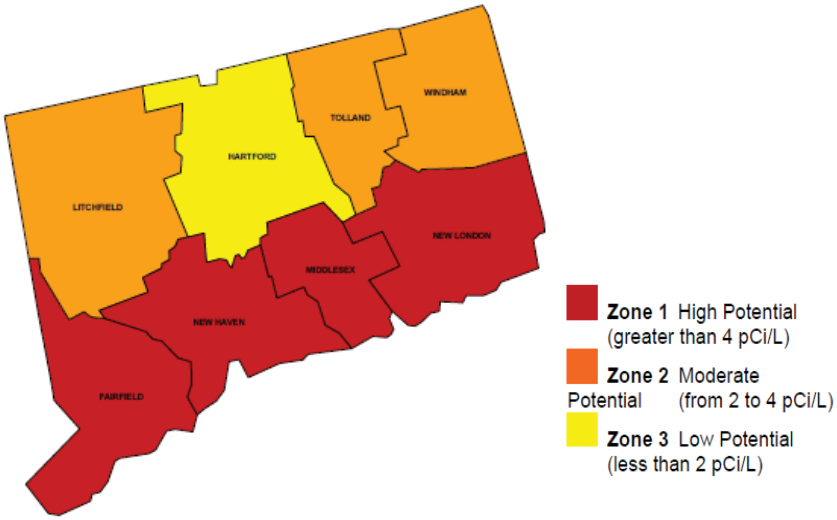
Air Quality

Air Quality Index AQI is a number used by government agencies to communicate to the public how polluted the air is currently or how polluted it is forecast to become. As the AQI increases, an increasingly large percentage of the population is likely to experience increasingly severe adverse health effects including asthma and cardiovascular disease. According to the U.S. Environmental Protection Agency in 2013 the Air Quality Index (AQI) was significantly worse in the city of Waterbury at 106 compared to the United States Index average of 75.

Radon Zones

According to the U.S. Environmental Protection Agency, New Haven County, which occupies Saint Mary's Hospital service area, falls within the EPA's Radon Zone 1 indicating a High Potential for radon exposure for that service area community. As stated by the World Health Organization, radon is the second most important cause of lung cancer in many countries and lung cancer risk rises 16% per 2.7 pCi/L increase in radon exposure.

Figure 2. Map of Radon Zones in Connecticut



Source: US EPA (2013); primary service area determined by Connecticut Hospital Association (2015)

Housing

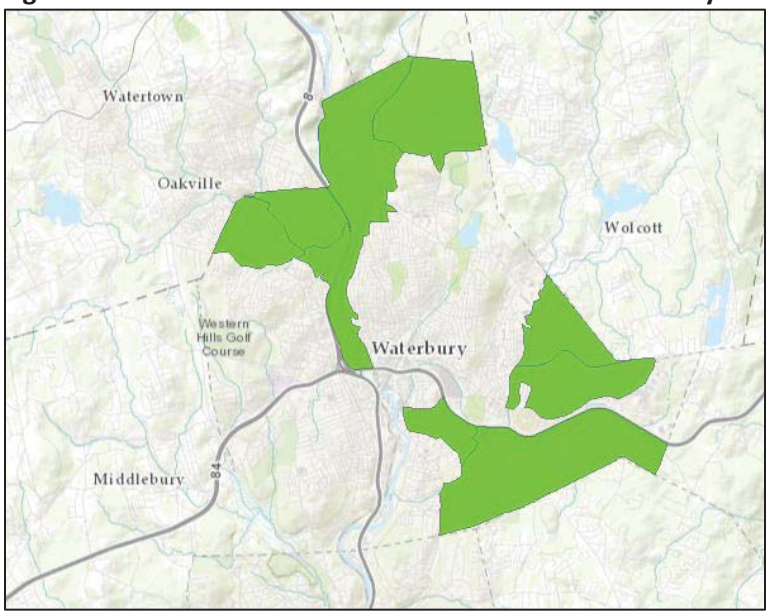
Housing insecurity is an issue that continues to impact Saint Mary's service area residents. Over a third of the population in Saint Mary's service area is housing cost burdened, with rates close to 35% in Waterbury (U.S. Census Bureau, 2010-2014). According to the US Census Bureau, housing cost burden is defined as more than 30% of income going towards housing expenses. A lack of affordable housing can contribute to many factors including homelessness and housing instability and insecurity.

Health Behaviors

The third factor to be discussed is health behaviors that account for 30% of the "Invest In Your Community" Model. This category includes topics such as diet, exercise, and substance use. These can also be defined as daily routines that residents in a community have that play a role in their overall health and wellbeing.

Diet and Exercise

Figure 3. USDA Food Atlas Food Desert Areas in Waterbury



Source: USDA Food Access Research Atlas; accessed 8/17/16

The USDA Food Access Research Atlas identifies low income and low access census tracts in order to greater understand the ability for members of the population to have access to a supermarket for nourishing and healthy food options. Places which have a great distance to a supermarket is known as a food desert. As seen in Figure 3 in green, Waterbury has several identified areas that are considered food deserts.

Table 9. Weekly Exercise

In an average week, how many days per week do you exercise?

	Connecticut	Greater Waterbury	Waterbury
None	17%	20%	26%
One	6%	5%	6%
Two	13%	10%	10%
Three	19%	20%	17%
Four	12%	10%	8%
Five	12%	12%	12%
Six	5%	4%	2%
Seven	16%	17%	17%
Don't Know	1%	1%	1%
Refused	1%	1%	1%

Source: DataHaven Health and Wellbeing Survey

Table 10. Body Mass Index
BMI (Based on Q24 Weight and Q25 Height DataHaven Survey)

	Connecticut	Greater Waterbury	Waterbury
Underweight	2%	2%	2%
Normal weight	37%	33%	27%
Overweight	36%	37%	37%
Obese	26%	28%	33%

Source: DataHaven Health and Wellbeing Survey

Alcohol and Substance Use

Substance use in the state of Connecticut and specifically in the city of Waterbury has been a large public health concern with the rising rates overdose cases. As one of the top five conditions for Saint Mary's Emergency Department non-admission rates, substance use and abuse remains a problem in particular with prescription and opioid based medications.

Tobacco Use

Tobacco use is a major concern in Waterbury especially with the number of residents who currently smoke on a daily basis. According to the DataHaven Health and WellBeing Survey 45.0% of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 40.0% across the state. In addition, more than half (55.0%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (37.0%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months by not smoking for 24 hours or more.

Table 11. Current Tobacco Use
(If smoked 100 cigarettes in entire life) Do you currently smoke cigarettes every day, some days or not at all?

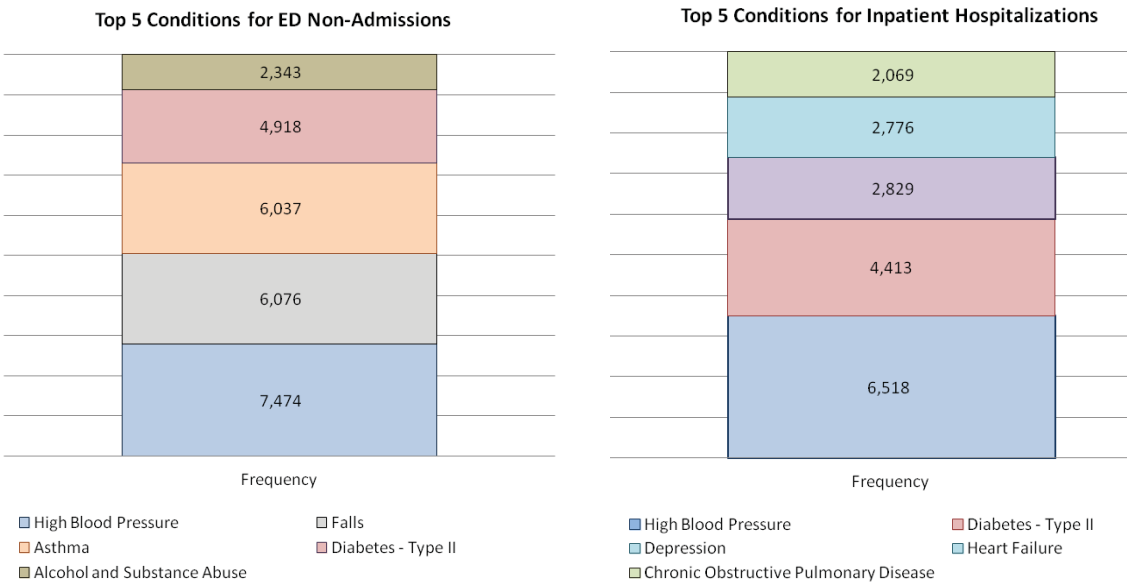
	Connecticut	Greater Waterbury	Waterbury
Every day	26%	29%	40%
Some days	11%	11%	15%
Not at all	63%	60%	45%
Don't know	0%	0%	0%
Refused	0%	0%	0%
Smoking Prevalence (based on several questions in DataHaven Survey)	15%	17%	25%

Source: DataHaven Health and Wellbeing Survey

Clinical Care

The last factor that is mentioned in the CDC model is clinical care, which accounts for 20% of good health. To better understand this for Saint Mary's primary service area several data sets have been used from the Connecticut Hospital Association in order to better understand the access to care as well as the quality of care given to patients.

Figure 4. Inpatient Hospitalizations and Conditions for ED Non-Admissions

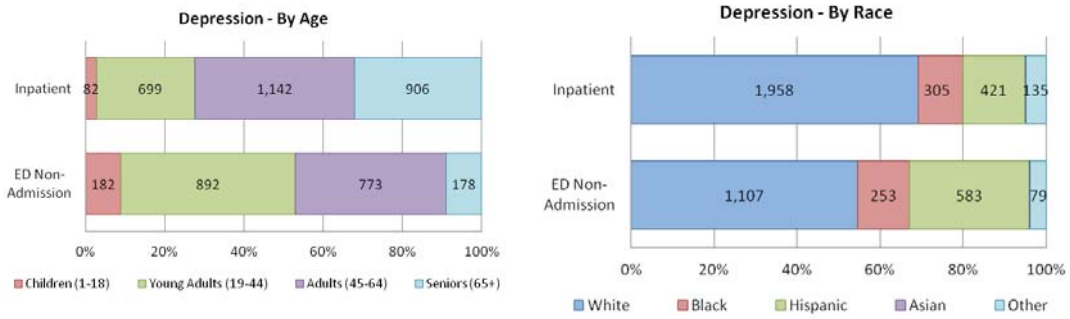


Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Mental Health

Mental and Behavioral Health continue to have a dramatic impact on the overall health of residents in the Saint Mary's service area. Feeling physically unwell can impact a person's emotional wellbeing and if not taken seriously can lead to depression and anxiety. As seen in the figures below, the largest group of patients at Saint Mary's were white adults age 45 to 64 according to the 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association.

Figure 5. Depression by Age and Race



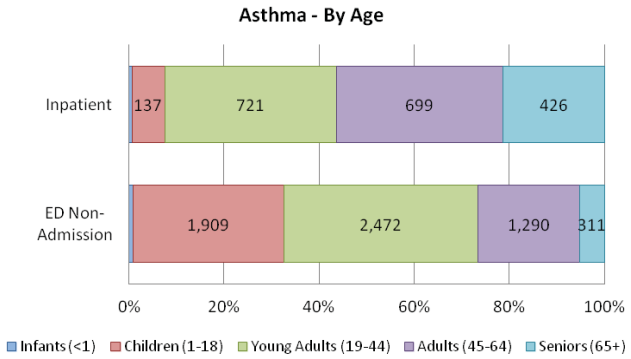
Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

In addition to depression, suicide and self-inflicted injuries were an increasing health concern for the hospital with 243 ED non-admission patients of which 142 were insured with Medicaid (Connecticut Hospital Association, 2015).

Asthma

In Greater Waterbury there are fare to many area children and adults that have poorly managed asthma which results in significant amounts of emergency department visits and potential inpatient admissions. Both pediatric and adult asthmatics have potential gaps in the education of management of asthma and its potential life threating symptoms. Despite being in line with the Connecticut average of respondents having Asthma in the Greater Waterbury Area and City of Waterbury, of the respondents that answered "yes" to having Asthma the rate was double the Connecticut average at (12% and 16% respectively) for having an Asthma attack at least once a day and using a prescription inhaler (DataHaven Health and Wellbeing Survey, 2015).

Figure 6. Asthma by Age



Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Oral Health

According to the American Dental Association, most dental Emergency Room visits can be reduced or eliminated by regular visits to a dentist. In the DataHaven Health and Wellbeing Survey, almost 1 in 3 residents of Waterbury reported not have been to a dentist for more than a year (2015). In addition, Emergency Department visits for dental conditions were proportionally overrepresented among blacks and Hispanics in Saint Mary's service area.

Cancer

Cancer affects Waterbury residents at an (age-adjusted) rate of 491.1 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 491.1 is similar to or lower than that of peer cities such as Hartford and New Haven which can be seen in Table 13.

Table 12. Cancer Incidence in Waterbury per 100,000 (2010)

Primary Cancer Site	Crude Rate	Age-Adjusted Rate
Breast (Female)	139.0	128.9
Colorectal*	60.0	57.6
Lung & Bronchus*	77.4	74.8
Prostate	115.4	120.8
All sites	506.3	491.1

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health
*Denotes that State-Town Comparison rates are higher than the state rate.

Table 13. Cancer Incidence by City per 100,000 (2010)

	Connecticut	Waterbury	Hartford	New Haven
All sites (Age-adjusted)	489.3	491.1	472.5	515.9

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health

The mortality rate per 100,000 for all cancer types is 146.7 in Connecticut which is surpassing the Healthy People 2020 target of 161.4 (2014).

Table 14. Overall Cancer Deaths by Total in Connecticut

	2010	2011	2012	2013	2014
Total*	163.4	158.4	151.9	148.4	146.7

Source: Healthy People 2020 (2014), State-Level Data: Connecticut
*Total (Age adjusted, per 100,000 population)

Diabetes

Not only in the Saint Mary's service area and the state of Connecticut has diabetes been a major health concern but across the United States. According to the Center for Disease Control, 29 million Americans have diabetes and 86 million American adults aged 20 years and older have prediabetes. As seen below, residents in Waterbury have been told by a doctor more frequently that they have diabetes than in the Greater Waterbury area and in Connecticut. The unease with this number is that residents that have diabetes are at higher risk for serious health complications including: blindness, kidney failure, heart disease, stroke, and potential loss of extremities.

Table 15. Have you ever been told by a doctor or health professional that you have diabetes?

Connecticut	Greater Waterbury	Waterbury
9%*	11%*	13%*

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

Cardiovascular Disease

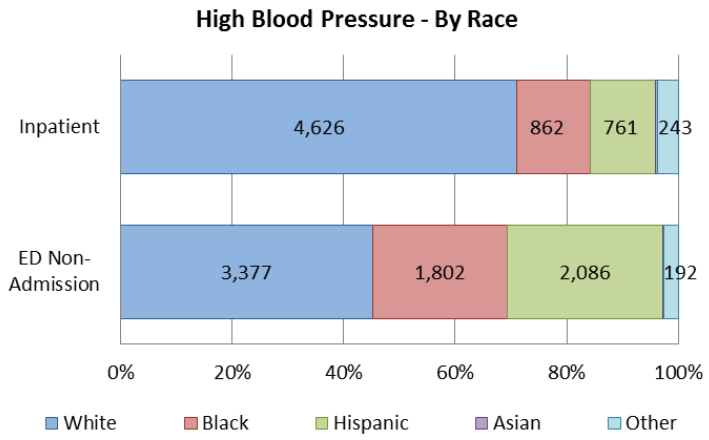
According to the Connecticut Hospital Association, high blood pressure was the most prevalent condition among inpatient and Emergency Department Non-Admission settings. A total of 35% of residents in Waterbury responded "yes" to having been told by their doctor or health professional that they had high blood pressure or hypertension which are contributing factors to (other than obesity and lack of physical exercise) to more serious cardiovascular disease.

Table 16. Have you ever been told by a doctor or health professional you have high blood pressure or hypertension?

Connecticut	Greater Waterbury	Waterbury
28%*	32%*	35%*

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

Figure 7. High Blood Pressure by Race



Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

Barriers to Care

Access to care remains one of the top concerns for Saint Mary's and its patients in the community. The tables below report access to services, insurance and prescription medications from the DataHaven Health and Wellbeing Survey.

Table 17. During the past 12 months, was there any time when you didn't get the medical care you needed?

	Connecticut	Greater Waterbury	Waterbury
Yes	7%	9%	10%
No	92%	91%	89%
Don't know	0%	0%	0%
Refused	0%	0%	1%

Source: DataHaven Health and Wellbeing Survey

Table 18. And was there any time during the past 12 months when you put off or postponed getting medical care you thought you needed?

	Connecticut	Greater Waterbury	Waterbury
Yes	21%	20%	22%
No	79%	80%	77%
Don't know	0%	0%	0%
Refused	1%	0%	0%

Source: DataHaven Health and Wellbeing Survey

Table 19. If postponed or medical care not given, what was the reasoning?

	Connecticut	Greater Waterbury	Waterbury
Cost	49%	45%	45%
Health insurance was not accepted (Doctor's office or Hospital)	16%	12%	14%
Health insurance did not cover treatment	28%	33%	35%
Appointment was not in a reasonable amount of time	25%	27%	30%
The medical problem did not seem serious enough	46%	43%	39%

Source: DataHaven Health and Wellbeing Survey

Strategies to Address Community Health Needs

Selection of the Community Health Priorities and Future Planning

In May 2016, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the GWHIP data and planning for the future. The meeting was initiated by partners of the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss the commitment to the Greater Waterbury area and discuss future prioritizations of the organization and its members.

The objectives of the session were:

- To review recently compiled DataHaven Community Health and Wellbeing data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

Prioritization Process

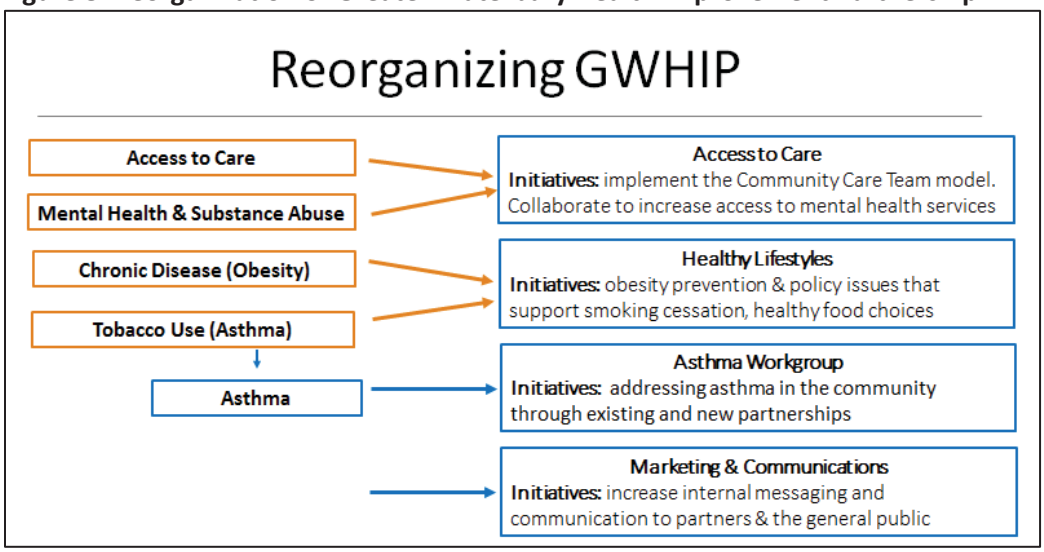
Executive leaders of the Connecticut Community Foundation, City of Waterbury Health Department, and Greater Waterbury Health Improvement Partnership facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview of the DataHaven Health and Wellbeing Data, meeting participants were provided with information regarding the prioritization process, criteria to consider moving forward with key areas of focus, and other aspects of health improvement planning. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community and how they would fit into the prioritization areas.

Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted in order to touch on several health initiatives:

Figure 8. Reorganization of Greater Waterbury Health Improvement Partnership



Strategies to Address Community Health Needs

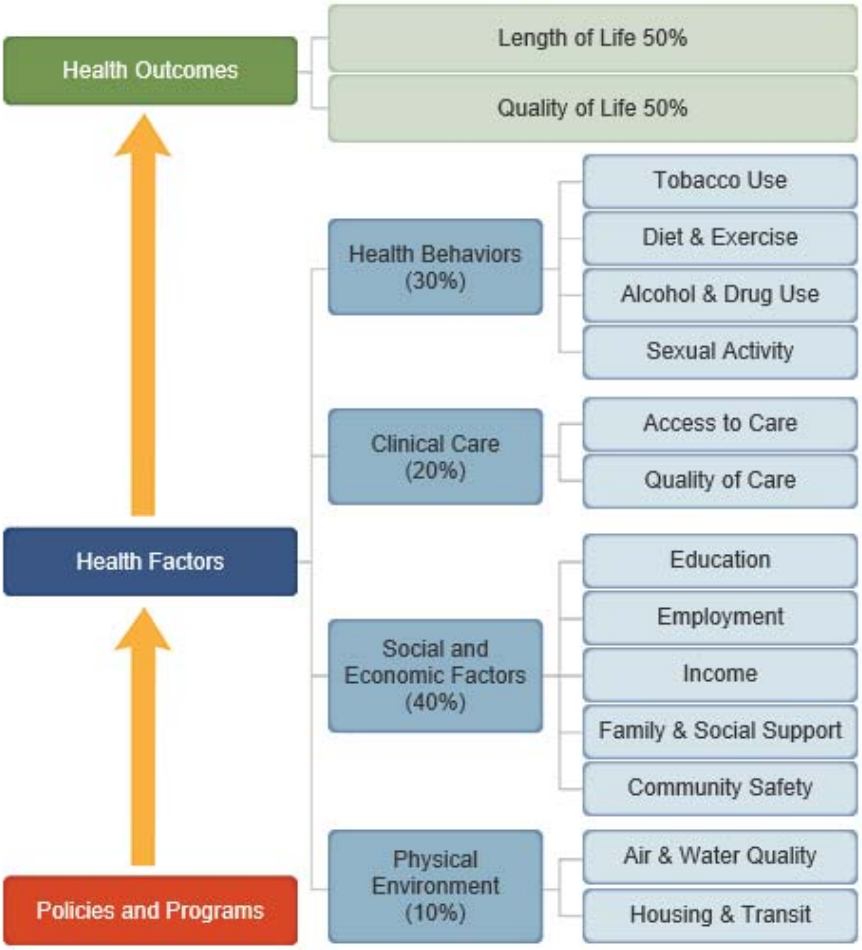
Saint Mary's Hospital will develop an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work will be completed by February 15, 2017 is supported by community-wide efforts and leadership from the executive team and board of directors.

Rationale for Community Health Needs Not Addressed

Saint Mary's Hospital plans to address all of the prioritized community health needs identified through the 2016 Community Health Needs Assessment and prioritized by community representatives.

Invest in Your Community Template

County Health Rankings Model - Health Factors



Appendices

Appendix 1. Community Health Rankings

Saint Mary's Hospital County Health Rankings

Health Outcomes Rank of 6 (out of 8 counties)

Health Factors Rank of 7 (out of 8 counties)

Measures	New Haven County	Litchfield County	Hartford County	State
Health Outcomes				
Length of Life				
Premature death /100,000	5800	5500	5700	5300
Quality of Life				
% Adults reporting fair or poor health	13%	9%	13%	14%
Avg. physically unhealthy days/month	2.9	2.5	3.1	3.2
Avg. mentally unhealthy days/month	3.5	3.2	3.4	3.7
% Live births with low birth weight <2500g	8%	7%	9%	8%
Health Factors				
Health Behaviors				
% Adults report currently smoking cigarettes	14%	13%	13%	15%
% Adults reporting BMI >= 30	26%	23%	27%	25%
Food environment index	7.6	8.5	7.7	7.9
% Adults 20+ reporting no leisure-time physical activity	23%	21%	23%	22%
% Pop. with adequate access to locations for physical activity	96%	90%	96%	94%
% Adults reporting binge drinking	16%	19%	17%	18%
% Alcohol-impaired driving deaths	28%	28%	37%	33%
Chlamydia rate /100,000	440.3	174.4	418.9	355.8
Teen birth rate /1,000 female pop., ages 15-19	22	11	24	19
Clinical Care				
% Pop. under age 65 without health	11%	10%	10%	11%
Ratio of pop. to primary care physicians	1060: 1	1570: 1	1070: 1	1170: 1
Ratio of pop. to dentists	1360: 1	1650: 1	1000: 1	1230: 1
Ratio of pop. to mental health providers	270: 1	490: 1	230: 1	300: 1
Preventable hospital stays /1,000 Medicare	53	49	51	50
% Diabetic Medicare enrollees receiving	85%	88%	87%	86%
% Female Medicare enrollees receiving mammography	65%	65%	68%	67%
Social & Economic Factors				
% Students who graduate HS in 4 years	81%	89%	82%	86%
% Adults, age 25-44 with some college	65%	66%	68%	68%
% Pop. age 16+ unemployed but seeking work	7.2%	5.9%	6.9%	6.6%
% Under age 18 in poverty	18%	9%	18%	15%
% Adults without social/emotional support	N/A	N/A	N/A	N/A
% Children in single parent households	36%	21%	37%	31%
Violent crime /100,000	406	111	323	279
Injury mortality /100,000	57	57	56	53
Physical Environment				
Avg. daily fine particulate matter in micrograms/cubic meter (PM2.5)	10.5	10.7	10.5	10.5
% Pop. potentially exposed to water exceeding a violation limit /yr	N/A	N/A	N/A	N/A
% Households with severe housing problems	22%	16%	18%	19%
% Workforce driving alone to work	79%	83%	81%	79%
% Commuting 30+ mins to work, driving alone	32%	38%	27%	32%

Trinity Health
New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

November 30, 2016

RE: Docket Number: Trinity Health – New England Transfer of Ownership CON Conditions for:

- Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-31979-CON Transfer of Ownership of Saint Francis *Care*, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care*, Inc.

Dear Mrs. Roberts,

In accordance with Trinity Health – New England's approved CONs for the transfers of ownership of Saint Francis *Care,* Inc*,.* and Saint Mary's Health Systems, Inc. to Trinity Health Corporation and Trinity Health - New England and for the transfer of ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc*. (NKA Trinity Health – New England),* attached are the responses to the conditions set forth in each of the CON decisions.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

Docket Number: 15-32045-CON
Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

November 30, 2016

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Roberts:

In accordance with Items 6, 7, 8, 9 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

6. ***Until such time as the Services Plan is submitted, TH-NE shall provide OCHA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OCHA is imposing this Condition to ensure continued access to health care services for patient population.***

   In accordance with Condition 6 of the Order, Trinity Health – New England, Inc. ("TH-NE") is notifying OCHA that there are no plans to reallocate inpatient beds or relocate any outpatient services for Saint Mary's Hospital at this time.

7. ***Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:***
   - ***A. A list of the of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and***
   - ***B. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and***
   - ***C. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.***

   The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer.

   See Attachment 1.

8. ***For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:***

   a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The

categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category for the semi-annual period; and

Since August 1, 2016, the leaders within the functional areas at Saint Mary's Hospital have been working closely with Trinity Health and Trinity Health New England to identify and implement changes to realize cost savings opportunities. This process takes time to implement and we have not implemented any significant costs savings in the two month period ending September 30, 2016.

2. the effect of these cost savings on the clinical quality of care.

There has been no impact to clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/300 (statement of operations), or successor reports.

See Attachment 2.

9. ***For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016.***

   See Attachment 3 for financial indicators.

10. ***TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.***

In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 2

DESCRIPTION	CLASS	TYPE	ACQ DATE	AMT	Explanation	To be paid from
FABIUSTIRO ANESTHESIA MACHINES	MOVEABLE	MEDICAL	8/31/2016	59,992.08	2 new Anesthesia Fabious Tiro machines	Operating cash
INTELLIVUE MONITORS & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	50,254.20	2 new patient monitors with easy care cuffs	Operating cash
STERILIZATION CONTAINER	MOVEABLE	MEDICAL	8/31/2016	13,894.57	new sterilization container w/accessories	Operating cash
ISTAT 1 WIRELESS ANALYZER	MOVEABLE	MEDICAL	8/31/2016	28,060.47	new ISTAT 1 WIRELESS ANALYZER	Operating cash
SCOPES 0 DEG & 30 DEG CURETTATE	MOVEABLE	MEDICAL	8/31/2016	9,618.00	new scopes and tray sterilization sterrads	Operating cash
VC- 10 VACUUM	MOVEABLE	MEDICAL	8/31/2016	5,205.50	VC- 10 VACUUM curettate system	Operating cash
BLADDER SCAN BVI 9400	MOVEABLE	MEDICAL	8/31/2016	18,316.00	new Bladder scan w/rolling cart	Operating cash
LIPOSCULTPTOR & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	19,376.45	new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
SUTURE RETRIEVER ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	38,916.00	SUTURE RETRIEVER ACCESSORIES	Operating cash
SCOPE HOPKINS 11 30 DEG	MOVEABLE	MEDICAL	8/31/2016	9,300.40	Sheath High flow arthroscopy & Hopkins scope	Operating cash
B3000 BLACK BADGE & BATTERIES	MOVEABLE	MEDICAL	8/31/2016	20,552.00	B3000 BLACK BADGE & BATTERIES	Operating cash
CO2 MONITOR & ACCESSORIES	MOVEABLE	MEDICAL	8/31/2016	5,453.04	CO2 MONITOR & ACCESSORIES	Operating cash
ARTIC SUN 5000E TEMP	MOVEABLE	NONMEDICAL	8/31/2016	50,494.00	Artic Sun 5000E Temp manage system & calibration test unit	Operating cash
OPTIPLEX 7040 PC & MONITORS	MOVEABLE	NONMEDICAL	8/31/2016	27,050.40	20 monitors & 10 Optiplex 7040 SFF w/dual monitor stands	Operating cash
BUILDING SIGN	MOVEABLE	NONMEDICAL	8/31/2016	2,200.00	new bldg signage	Operating cash
CONDENSING UNIT	MOVEABLE	NONMEDICAL	8/31/2016	23,316.00	replace condensing unit	Operating cash
HVAC CLEANING & SANTIZING	MOVEABLE	NONMEDICAL	8/31/2016	23,203.50	HVAC duct CLEANING & SANTIZING	Operating cash
FIRE & SMOKE DAMPER	MOVEABLE	NONMEDICAL	8/31/2016	3,650.00	FIRE & SMOKE DAMPER	Operating cash
FLOOR SCRUBBERS SINGLE & DUAL	MOVEABLE	NONMEDICAL	8/31/2016	14,248.40	New Floor scrubbers (single & dual) and burnisher	Operating cash
DEHUMIDIFIER TRAGER BASEMENT	MOVEABLE	NONMEDICAL	8/31/2016	2,647.50	deposit for DEHUMIDIFIER in TRAGER BASEMENT	Operating cash
EXPANSION VALVE TRAGER	MOVEABLE	NONMEDICAL	8/31/2016	2,618.00	depoisit for EXPANSION VALVE in TRAGER office	Operating cash
WALL COVERING - AUDITORIUM	MOVEABLE	NONMEDICAL	8/31/2016	10,530.30	deposit for WALL COVERING in AUDITORIUM	Operating cash
COOLONG COL REPLACEMENT	MOVEABLE	NONMEDICAL	8/31/2016	45,350.00	AHU-1 Cooling coil replacement	Operating cash
CATH LAB # 2 RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	70,203.36	CATH LAB # 2 RENOVATION	Operating cash
SLEEP LAB RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	24,400.75	SLEEP LAB RENOVATION	Operating cash
BOARDROOM RENOVATION	BLDG IMPR	NONMEDICAL	8/31/2016	18,518.50	Boardroom Project is now complete	Operating cash
10 FT HOSES	MOVEABLE	NONMEDICAL	8/31/2016	647.44	4 each of 02 CS hoses & Air CS hoses 10FT Diss Hand	Operating cash
REVERSE OSMOSIS SYSTEM	MOVEABLE	NONMEDICAL	8/31/2016	16,500.00	REVERSE OSMOSIS SYSTEM	Operating cash
HARMONYAIR LIGHT SYSTEM	FIXED	NONMEDICAL	8/31/2016	49,805.83	2 Harmonyair G5 Dual Pkg Light systems	Operating cash
RECUMBENT CROSS TRAINER	MOVEABLE	MEDICAL	9/30/2016	4,189.00	RECUMBENT CROSS TRAINER-the Foundation reimbursed us for this purchase	Foundation Funds
CONTAINERS FOR STERILIZATION	MOVEABLE	MEDICAL	9/30/2016	5,130.40	75 sterilization containers	Operating cash
TITANIUM GE MRI TOOL KIT	MOVEABLE	MEDICAL	9/30/2016	3,775.95	TITANIUM GE MRI TOOL KIT	Operating cash
LIPOTOWER ASPIRATOR / INFIL	MOVEABLE	MEDICAL	9/30/2016	6,922.35	new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
LIGHT HANDLE CAMERA COVER	MOVEABLE	MEDICAL	9/30/2016	295.92	LIGHT HANDLE CAMERA COVER	Operating cash
CART, SINGLE TIER CORNER	MOVEABLE	MEDICAL	9/30/2016	10,865.17	CART, SINGLE TIER CORNER	Operating cash
CAMERA, CODER & STORAGE	MOVEABLE	MEDICAL	9/30/2016	5,500.00	CAMERA, CODER & STORAGE	Operating cash
VOLUSON P8	MOVEABLE	MEDICAL	9/30/2016	8,480.00	VOLUSON P8	Operating cash
CARBON FIBER BOARD	MOVEABLE	NONMEDICAL	9/30/2016	2,250.00	Board, Carbon fiber TTL ACS Radial	Operating cash

CHESHIRE UC INSTALL	FIXED	NONMEDICAL	9/30/2016	8,485.00	Security Alarm install	Operating cash
DELL OPTOPLEX 7040	MOVEABLE	NONMEDICAL	9/30/2016	14,596.44	24 monitors & 12 Optiplex 7040 SFF w/dual monitor stands, plus software	Operating cash
MARKETING FURNITURE	MOVEABLE	NONMEDICAL	9/30/2016	7,144.73	MARKETING FURNITURE-chairs, credenza, tabletop, etc	Operating cash
NVSC PAINTING (WATER DAMAGE)	BLDG IMPR	NONMEDICAL	9/30/2016	5,020.00	interior painting from water damage	Operating cash
NVSC PAINTING (WATER DAMAGE)	BLDG IMPR	NONMEDICAL	9/30/2016	28,024.00	interior painting from water damage	Operating cash
COUNTER FOR PSYCHIATRIC WARD	FIXED	NONMEDICAL	9/30/2016	2,527.20	Counter Fabrication	Operating cash
FEASABILITY STUDY OPEN OFFICE	BLDG IMPR	NONMEDICAL	9/30/2016	2,545.00	Prof srvs for FEASABILITY STUDY OPEN OFFICE	Operating cash
COUNTER TOPS THROUGHOUT HOSPITAL	FIXED	NONMEDICAL	9/30/2016	15,880.90	Labor & Materials for COUNTER TOPS THROUGHOUT HOSPITAL	Operating cash
AUDITORIUM RENOVATION	BLDG IMPR	NONMEDICAL	9/30/2016	18,662.55	Prof Srvs for AUDITORIUM RENOVATION	Operating cash
FIRE STOP	BLDG IMPR	NONMEDICAL	9/30/2016	9,818.00	FIRE STOP Labor & Materials	Operating cash
MAIN MEGAWATT METER REPLACEMENT	FIXED	NONMEDICAL	9/30/2016	2,750.00	MAIN MEGAWATT METER REPLACEMENT	Operating cash
EPOXY COATED SHOWER BASE	MOVEABLE	NONMEDICAL	9/30/2016	10,455.00	EPOXY COATED SHOWER BASE	Operating cash
BLASIUS 2014 CHEVROLET CRUZE	AUTO	NONMEDICAL	9/30/2016	12,805.60	BLASIUS 2014 CHEVROLET CRUZE	Operating cash
SLEEP LAB BUDGETED CONTRACT	BLDG IMPR	NONMEDICAL	9/30/2016	49,863.27	SLEEP LAB RENOVATION	Operating cash
MEP	BLDG IMPR	NONMEDICAL	9/30/2016	1,400.00	MEP-SLEEP LAB RENOVATION	Operating cash
RODI PIPING & INSTALL	FIXED	NONMEDICAL	9/30/2016	13,500.00	RODI PIPING & INSTALL	Operating cash

Regular additions	915,209.17
CIP project addtions	2,156,778.13
Total additions	3,071,987.30

Project Name	Project Description	Balance as of 7/31/16	Aug-Sep Additions	Balance as of 9/30/16	Project Start Date	Project expected end date	Project Budget	To be paid from
Oncology Center Project	Renovations to Dr Bowen's office located in the HLRCC	495,723.17	145,129.30	640,852.47	Apr-16	FY 2017	940,000	Operating cash
MRI Project	Renovations to new MRI area and Behavoiral Health in Emer Rm - 4 Phases to project	3,387,211.50	591,856.05	3,979,067.55	Sep-15	FY 2017	5,800,000	Operating cash, plus a 767,013 from a State grant
Atrion Project	Phase I of new phone system project	529,483.69	38,021.76	567,505.45	Jan-16	Nov-16	652,550	Operating cash
Cheshire Project	New construction for a Cheshire Urgent Care Ctr and a Primary Care/Specialty Practice	411,202.86	1,173,005.58	1,584,208.44	Mar-16	FY 2017	2,320,388	Operating cash
Northwest 911 Project	Renovations to 2nd floor of Lawlor Bldg for 911 Call Center	342,014.94	6,475.00	348,489.94	Feb-16	Nov-16	250,000	Operating cash
Cardiac Cath Lab Project	Renovations for a new Cardiac Cath Lab	450,631.00	198,601.69	649,232.69	May-16	FY 2017	815,823	Operating cash
Naugatuck Urgent Care	Construction for a new Urgent Care Ctr in Naugatuck - Project was put off until after FY2017, expenses were for Architect designs	7,377.50	3,688.75	11,066.25	FY 2018	FY 2019	2,100,000	Operating cash
		Total	2,156,778.13					

ATTACHMENT 2

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$13,310,000	$20,572,000	$7,262,000	55%
2	Short Term Investments	$17,000	$23,000	$6,000	35%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$28,548,000	$24,965,000	($3,583,000)	-13%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,701,000	$3,889,000	$188,000	5%
8	Prepaid Expenses	$3,301,000	$2,930,000	($371,000)	-11%
9	Other Current Assets	$3,792,000	$3,114,000	($678,000)	-18%
	Total Current Assets	**$52,669,000**	**$55,493,000**	**$2,824,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$14,764,000	$15,480,000	$716,000	5%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$20,166,000	$6,000	($20,160,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$34,930,000**	**$15,486,000**	**($19,444,000)**	**-56%**
5	Interest in Net Assets of Foundation	$4,908,000	$5,549,000	$641,000	13%
6	Long Term Investments	$124,000	$10,973,000	$10,849,000	8749%
7	Other Noncurrent Assets	$25,663,000	$25,740,000	$77,000	0%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$205,415,000	$91,358,000	($114,057,000)	-56%
2	Less: Accumulated Depreciation	$139,994,000	$2,656,000	($137,338,000)	-98%
	Property, Plant and Equipment, Net	**$65,421,000**	**$88,702,000**	**$23,281,000**	**36%**
3	Construction in Progress	$0	$7,780,000	$7,780,000	0%
	Total Net Fixed Assets	**$65,421,000**	**$96,482,000**	**$31,061,000**	**47%**
	Total Assets	**$183,715,000**	**$209,723,000**	**$26,008,000**	**14%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$21,871,000	$15,420,000	($6,451,000)	-29%
2	Salaries, Wages and Payroll Taxes	$3,962,000	$5,045,000	$1,083,000	27%
3	Due To Third Party Payers	$727,000	$1,262,000	$535,000	74%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$3,180,000	$89,000	($3,091,000)	-97%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$13,976,000	$15,912,000	$1,936,000	14%
	Total Current Liabilities	**$43,716,000**	**$37,728,000**	**($5,988,000)**	**-14%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$10,589,000	$0	($10,589,000)	-100%
	Total Long Term Debt	**$10,589,000**	**$0**	**($10,589,000)**	**-100%**
3	Accrued Pension Liability	$74,894,000	$83,306,000	$8,412,000	11%
4	Other Long Term Liabilities	$9,352,000	$10,485,000	$1,133,000	12%
	Total Long Term Liabilities	**$94,835,000**	**$93,791,000**	**($1,044,000)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$27,411,000	$59,686,000	$32,275,000	118%
2	Temporarily Restricted Net Assets	$1,922,000	$1,970,000	$48,000	2%
3	Permanently Restricted Net Assets	$15,831,000	$16,548,000	$717,000	5%
	Total Net Assets	**$45,164,000**	**$78,204,000**	**$33,040,000**	**73%**
	Total Liabilities and Net Assets	**$183,715,000**	**$209,723,000**	**$26,008,000**	**14%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$746,752,000	$136,060,000	($610,692,000)	-82%
2	Less: Allowances	$483,477,000	$90,093,000	($393,384,000)	-81%
3	Less: Charity Care	$3,174,000	$1,021,000	($2,153,000)	-68%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$260,101,000**	**$44,946,000**	**($215,155,000)**	**-83%**
5	Provision for Bad Debts	$8,180,000	$935,000	($7,245,000)	-89%
	Net Patient Service Revenue less provision for bad debts	**$251,921,000**	**$44,011,000**	**($207,910,000)**	**-83%**
6	Other Operating Revenue	$8,206,000	$1,078,000	($7,128,000)	-87%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$260,127,000**	**$45,089,000**	**($215,038,000)**	**-83%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$88,793,000	$15,392,000	($73,401,000)	-83%
2	Fringe Benefits	$27,562,000	$4,065,000	($23,497,000)	-85%
3	Physicians Fees	$6,099,000	$1,655,000	($4,444,000)	-73%
4	Supplies and Drugs	$41,890,000	$7,502,000	($34,388,000)	-82%
5	Depreciation and Amortization	$11,023,000	$2,659,000	($8,364,000)	-76%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$963,000	$5,000	($958,000)	-99%
8	Malpractice Insurance Cost	$3,338,000	$798,000	($2,540,000)	-76%
9	Other Operating Expenses	$61,720,000	$9,341,000	($52,379,000)	-85%
	Total Operating Expenses	**$241,388,000**	**$41,417,000**	**($199,971,000)**	**-83%**
	Income/(Loss) From Operations	**$18,739,000**	**$3,672,000**	**($15,067,000)**	**-80%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,315,000	$56,000	($1,259,000)	-96%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$1,207,000	($11,000)	($1,218,000)	-101%
	Total Non-Operating Revenue	**$2,522,000**	**$45,000**	**($2,477,000)**	**-98%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$21,261,000**	**$3,717,000**	**($17,544,000)**	**-83%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$21,261,000**	**$3,717,000**	**($17,544,000)**	**-83%**
	*** FY16 represents the period 8/1/16 - 9/30/16**				

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$15,091,000	$22,818,000	$7,727,000	51%
2	Short Term Investments	$17,000	$23,000	$6,000	35%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$32,905,000	$29,301,000	($3,604,000)	-11%
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$3,418,000	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,701,000	$3,889,000	$188,000	5%
8	Prepaid Expenses	$3,300,000	$3,515,000	$215,000	7%
9	Other Current Assets	$4,618,000	$3,192,000	($1,426,000)	-31%
	Total Current Assets	**$63,050,000**	**$66,156,000**	**$3,106,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$14,764,000	$15,480,000	$716,000	5%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$43,057,000	$19,537,000	($23,520,000)	-55%
	Total Noncurrent Assets Whose Use is Limited:	**$57,821,000**	**$35,017,000**	**($22,804,000)**	**-39%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$4,244,000	$15,428,000	$11,184,000	264%
7	Other Noncurrent Assets	$11,454,000	$6,263,000	($5,191,000)	-45%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$219,963,000	$95,973,000	($123,990,000)	-56%
2	Less: Accumulated Depreciation	$149,672,000	$2,835,000	($146,837,000)	-98%
	Property, Plant and Equipment, Net	**$70,291,000**	**$93,138,000**	**$22,847,000**	**33%**
3	Construction in Progress	$0	$7,873,000	$7,873,000	0%
	Total Net Fixed Assets	**$70,291,000**	**$101,011,000**	**$30,720,000**	**44%**
	Total Assets	**$206,860,000**	**$223,875,000**	**$17,015,000**	**8%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$22,665,000	$16,465,000	($6,200,000)	-27%
2	Salaries, Wages and Payroll Taxes	$6,002,000	$8,160,000	$2,158,000	36%
3	Due To Third Party Payers	$727,000	$1,262,000	$535,000	74%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$3,409,000	$337,000	($3,072,000)	-90%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$12,980,000	$13,842,000	$862,000	7%
	Total Current Liabilities	**$45,783,000**	**$40,066,000**	**($5,717,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$11,018,000	$586,000	($10,432,000)	-95%
	Total Long Term Debt	**$11,018,000**	**$586,000**	**($10,432,000)**	**-95%**
3	Accrued Pension Liability	$74,894,000	$83,306,000	$8,412,000	11%
4	Other Long Term Liabilities	$24,062,000	$22,539,000	($1,523,000)	-6%
	Total Long Term Liabilities	**$109,974,000**	**$106,431,000**	**($3,543,000)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$955,000	$2,588,000	$1,633,000	171%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$32,395,000	$56,272,000	$23,877,000	74%
2	Temporarily Restricted Net Assets	$1,922,000	$1,970,000	$48,000	2%
3	Permanently Restricted Net Assets	$15,831,000	$16,548,000	$717,000	5%
	Total Net Assets	**$50,148,000**	**$74,790,000**	**$24,642,000**	**49%**
	Total Liabilities and Net Assets	**$206,860,000**	**$223,875,000**	**$17,015,000**	**8%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$832,217,000	$152,831,000	($679,386,000)	-82%
2	Less: Allowances	$536,081,000	$100,069,000	($436,012,000)	-81%
3	Less: Charity Care	$1,072,000	$1,021,000	($51,000)	-5%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$295,064,000**	**$51,741,000**	**($243,323,000)**	**-82%**
5	Provision for Bad Debts	$9,675,000	$1,442,000	($8,233,000)	-85%
	Net Patient Service Revenue less provision for bad debts	**$285,389,000**	**$50,299,000**	**($235,090,000)**	**-82%**
6	Other Operating Revenue	$10,072,000	$1,365,000	($8,707,000)	-86%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$295,461,000**	**$51,664,000**	**($243,797,000)**	**-83%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$123,197,000	$22,400,000	($100,797,000)	-82%
2	Fringe Benefits	$32,298,000	$4,765,000	($27,533,000)	-85%
3	Physicians Fees	$9,916,000	$1,659,000	($8,257,000)	-83%
4	Supplies and Drugs	$43,411,000	$7,978,000	($35,433,000)	-82%
5	Depreciation and Amortization	$11,636,000	$2,834,000	($8,802,000)	-76%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$980,000	$8,000	($972,000)	-99%
8	Malpractice Insurance Cost	$4,154,000	$1,088,000	($3,066,000)	-74%
9	Other Operating Expenses	$67,708,000	$11,150,000	($56,558,000)	-84%
	Total Operating Expenses	**$293,300,000**	**$51,882,000**	**($241,418,000)**	**-82%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016*	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Income/(Loss) From Operations	**$2,161,000**	**($218,000)**	**($2,379,000)**	**-110%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,565,000	$53,000	($1,512,000)	-97%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$963,000	($11,000)	($974,000)	-101%
	Total Non-Operating Revenue	**$2,528,000**	**$42,000**	**($2,486,000)**	**-98%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$4,689,000**	**($176,000)**	**($4,865,000)**	**-104%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$4,689,000**	**($176,000)**	**($4,865,000)**	**-104%**
	*** FY16 represents the period 8/1/16 - 9/30/16**				

ATTACHMENT 3

	Saint Mary's Hospital (Hospital Only)	Month		Year to Date	
		Sept 2016	Prior Year	Sept 2016*	Prior Year
A.	**Operating Performance**				
	Operating Margin	10.9%	9.0%	8.1%	7.2%
	Non-Operating Margin	0.1%	-6.0%	0.1%	1.0%
	Total Margin	11.0%	3.0%	8.2%	8.2%
	Bad Debt as % of Gross Revenue	0.1%	0.4%	0.7%	1.2%
B.	**Liquidity**				
	Current Ratio	1.76	1.62	1.79	1.62
	Days Cash on Hand	31	23	31	23
	Days in Net Accounts Receivable	37	41	37	41
	Average Payment Period	52	61	52	61
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	-	0.32	-	0.32
	Long-term Debt to Capitalization	-	0.24	-	0.24
	Unrestricted Cash to Debt	231.15	0.97	231.15	0.97
	Times Interest Earned Ratio	1170.1	30.5	735.40	22.65
	Debt Service Coverage Ratio	214.8	11.3	71.20	9.82
	Equity Financing Ratio	2.70	4.23	2.70	4.23
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 2,523	$ 1,821	$ 3,672	$ 18,739
	Revenue Over/(Under) Expense	$ 2,537	$ 601	$ 3,717	$ 21,261
	EBITDA	$ 3,866	$ 2,835	$ 6,335	$ 30,507
	Patient Cash Collected	$ 20,601	$ 18,920	$ 42,323	$ 239,372
	Cash and Cash Equivalents	$ 20,572	$ 13,310	$ 20,572	$ 13,310
	Net Working Capital	$ 17,764	$ 8,953	$ 17,764	$ 8,953
	Unrestricted Assets	$ 59,686	$ 27,411	$ 59,686	$ 27,411
	Credit Ratings (S&P, FITCH and Moody's)				

Note: September 2016 YTD is only for the period 8/1-9/30. The prior year YTD is the full fiscal year for FY15

	Saint Mary's Health System (Consolidated)	Month		Year to Date	
		Sept 2016	Prior Year	Sept 2016*	Prior Year
A.	**Operating Performance**				
	Operating Margin	1.3%	-0.1%	-0.4%	0.7%
	Non-Operating Margin	0.1%	-5.0%	0.1%	0.9%
	Total Margin	1.4%	-5.0%	-0.3%	1.6%
	Bad Debt as % of Gross Revenue	0.5%	0.7%	0.9%	1.1%
B.	**Liquidity**				
	Current Ratio	1.65	1.38	1.65	1.38
	Days Cash on Hand	27	19	27	19
	Days in Net Accounts Receivable	37	42	37	42
	Average Payment Period	52	58	52	58
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.01	0.29	0.01	0.28
	Long-term Debt to Capitalization	0.01	0.23	0.01	0.22
	Unrestricted Cash to Debt	24.72	0.98	24.72	0.98
	Times Interest Earned Ratio	37.4	-57.7	(26.30)	3.20
	Debt Service Coverage Ratio	44.4	4.9	7.79	4.33
	Equity Financing Ratio	2.88	4.05	2.88	4.05
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 332	$ (3)	$ (218)	$ 2,161
	Revenue Over/(Under) Expense	$ 373	$ (1,137)	$ (176)	$ 4,689
	EBITDA	$ 1,776	$ 1,240	$ 2,624	$ 14,777
	Patient Cash Collected	$ 23,617	$ 21,477	$ 48,614	$ 272,841
	Cash and Cash Equivalents	$ 22,818	$ 15,091	$ 22,818	$ 15,091
	Net Working Capital	$ 27,488	$ 17,267	$ 27,488	$ 17,267
	Unrestricted Assets	$ 56,272	$ 32,395	$ 56,272	$ 32,395
	Credit Ratings (S&P, FITCH and Moody's)				

Note: September 2016 YTD is only for the period 8/1-9/30. The prior year YTD is the full fiscal year for FY15

Docket Number: 15-31979-CON
Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation
Response to Item 9 of the Settlement and Order dated 8/1/2015
Annual Report for the Capital Investment Plan due 11/30/2016

Question 1

Provide a five-year post-closing capital investment plan detailing the proposed allocation of the $275 million capital investment commitment. The submitted plan shall account for the full $275 million commitment as stated in the proposal and include the following information:

a. A list of planned capital expenditures with detailed descriptions and associated estimated costs, and

Please refer to Attachment 1 for FY 2016 actual capital expenditures for the twelve month period ended September 30, 2016.

Attachment 2 includes the final approved capital budget (see column C) for Trinity Health –New England, Inc. (TH-NE) which has been approved by both Trinity Health's governing body as well as TH-NE's finance committee. The FY 2017 budget is for the period 7/1/2016-6/30/2017.

Attachment 2 has also been updated to reflect preliminary capital budget for FY 2018-2020. TH-NE, including Saint Francis Hospital and Medical Center, is in the process of developing their three to five year strategic plan. Future year's capital expenditures will be further defined and aligned with the outcome of the strategic planning process.

Since our last filing, Saint Mary's Hospital joined Trinity Health-New England. Attachment 2 has also been updated to reflect Saint Mary's FY 2017 routine and strategic capital budget. Furthermore, one critical investment necessary to effectively provide care to members of our community is to implement a single electronic health record across all of the hospitals and ambulatory providers. TH-NE will be investing in this technology at Saint Mary's and has allocated $20.5 million to this project.

b. A timeframe for the rollout of the capital projects, including estimated beginning, ending and start-up/operation dates.

See Attachment 3 for the FY 2017 individual capital projects greater than $500,000 that have been approved to proceed at Saint Francis. The remaining dollars relating to the capital budget will be allocated based upon current priorities and any critical needs that arise.

As the strategic plan is finalized and the more significant capital investments are identified, TH-NE will provide OHCA with an update for this stipulation. Trinity Health – New England, Inc. believes this approach will ensure the greatest accuracy as well as meet the intent of this stipulation.

Updated Capital Expenditure Summary 10/1/2015-9/30/2016

Entity	Service Line	Project Description	Budget	Actual Expenditures
Saint Francis Hospital and Medical Center	Facilities	Trinity Signage Branding	$ 627,000	$ -
Saint Francis Hospital and Medical Center	Facilities	Facilities Gen. - Renoc-Elect.Wholesalers Facility For Parking		$ 878,286
Saint Francis Hospital and Medical Center	Facilities	Gengras 5th Floor Renovations		$ 763,217
Saint Francis Hospital and Medical Center	Women and Infants	Women and Infants Build Out Addition to Women's Center	$ 1,000,000	553,569
Saint Francis Hospital and Medical Center	Facilities	Collins Parking Garage Repairs	$ 750,000	776,371
Saint Francis Hospital and Medical Center	Business Development	Various Construction Projects*	$ 1,000,000	-
Saint Francis Hospital and Medical Center	Cardiovascular	Cath Lab Renovation and Replacement FY16	$ 1,500,000	770,948
Saint Francis Hospital and Medical Center	Facilities	Renovation General - Office Renovations	$ 2,000,000	120,636
Saint Francis Hospital and Medical Center	Facilities	Renovation General - Burgdorf Renovation	$ 800,000	437,271
Saint Francis Hospital and Medical Center	Facilities: Engineering	Medical Office Building Renovations	$ 500,000	161,967
Saint Francis Hospital and Medical Center	Information Technology	Infrastructure Movement and Replacement of Data Center	$ 6,000,000	4,997,817
Saint Francis Hospital and Medical Center	Information Technology	EMC Project-Buid and Archive SFS Data To EMC		747,634
Saint Francis Hospital and Medical Center	Administration	Contingency FY16 Major Items	$ 1,220,229	-
Mount Sinai Hospital	Physical Medicine and Rehabilitation	Vision Center Renovation - Replace Back Center ***	$ 975,550	-
Mount Sinai Hospital	Physical Medicine and Rehabilitation	Replace 800K Absorber	$ 520,000	-
Saint Francis Medical Group	SFMG	Renovation for Rheumatology Bariatrics and Endocrine	$ 1,500,000	93,213
Saint Francis Hospital and Medical Center	CJRI	CJRI TWO O.R.s	$ 1,583,500	1,686,256
Saint Francis Hospital and Medical Center	Information Technology	Epic Ambulatory Implementation	$ 5,164,190	4,206,039
		Total of projects budgeted over $500,000 FY2016	**$ 25,140,469**	**$ 16,193,224**
Saint Francis Hospital and Medical Center	Strategic Investments	Acquisition of Johnson Memorial**	$ 20,015,000	$ 20,015,000
		Total of projects budgeted under $500,000 FY 2016	$ 12,778,531	$ 13,292,542
		Johnson Capital Expenditures		1,496,335
		Total Capital Budget for FY 2016 and Expenditures to Date	**$ 57,934,000**	**$ 50,997,102**
		Capital expenditures specific to Saint Francis	**$ 37,919,000**	**$ 29,485,767**

* Construction budget reduced to $250,000 to reallocate capital to other project
** $18 million funded through an intercompany loan from Trinity Health Corporate

Attachment 2
Preliminary Capital Investment Plan for Saint Francis *Care* , Inc.
Dollars in Thousands

	(a)	(b)	(C)	(d)			
	Five Year Total	Expenditures (10/1/2015-9/30/2016)	FY 2017 Budget (7/1/2016-6/30/2017)	FY 2018 Budget (7/1/2017-6/30/2018)	FY 2019 Budget (7/1/2018-6/30/2019)	FY 2020 Budget (7/1/2019-6/30/2020)	Estimated Five Year Capital Spend
Preliminary capital expenditures summary							
Investment in facilities, medical and non-medical equipment and technology	$ 184,000	21,428	$ 10,355	$ 25,000	$ 20,000	$ 20,000	$ 96,783
Capital leases associated with Epic and other	4,500	1,028	1,300				2,328
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	5,000	3,104	3,000	1,000	1,000		8,104
Expansion/renovations of clinical facilities	10,000		1,500	15,000			16,500
Physician acquisitions/ambulatory network development	23,500		3,200	2,500	2,500	2,500	10,700
Information Technology		3,926					3,926
Unspecified; to be allocated based on organizional priorities each year	48,000	20,015		5,000	10,000	15,000	50,015
							-
Adjustments to preliminary capital expenditure summary:							-
Reallocation to Johnson Memorial - part of strategic growth of RHM		1,496	1,512	3,000	3,000	1,500	10,508
Reallocation to Saint Mary's-part of strategic growth of RHM			20,272	15,000	15,000	20,000	70,272
Saint Mary's Epic Implementation			20,475				20,475
Total estimated annual capital expenditures	$ 275,000	$ 50,997	$ 61,614	$ 66,500	$ 51,500	$ 59,000	$ 289,611

(a) Preliminary plan for capital commitment as noted on page 635 of CON.
(b) Capital expenditures 10/1/2015-9/30/2016 see detail at Attachment 2 (SFHMC and Johnson acquistion)
(C) Budget for FY 2017 reduced due to Trinity Corporate financial objectives. Approved Trinity Health-New England Capital budget for Saint Francis and Johnson was $20,867,000
Saint Mary's routine and strategic capital for FY 2017 is $20,272,000. In addition, the implementation of Epic is $20,475,000 million.
(d) Amounts continue to be preliminary based on evolving RHM strategy and expected investment necessary for Saint Francis facilities and equipment, etc. Strategic plan currently being developed.
$15 million in FY 2018 for expansion of clinical facilities is for an Ambulatory Surgery Center (pending any required approvals and finalization of strategic plan)

Note: $20,015 in FY 2016 was investment in Johnson Memorial Hospital which closed on 1/1/2016

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Stipulation # 9

Attachment 3: Saint Francis Hospital and Medical Center Specific Projects Approved for FY 2017 (7/1/2016-6/30/2017) > $500,000

Project Type	Project Name (50 characters)	Long Description (250 characters)	2017 Budget
Clinical	Replace Beds	Critical Care SL, Department # 71800 - CICU	$ 881,136
IT	Infrastructure - Primary Backup Data Domain / Centera Growth	IT SL, Department # 15130 - IES	$ 600,000
Clinical	Stryker Power Equipment	CJRI SL, Department # 50020 - CJRI OR	$ 1,302,000
Clinical	OMNINAV Robotic Unit	CJRI SL, Department # 50020 - CJRI OR	$ 500,000
Clinical	Tele monitors for Bldg 1 and 2	Tele monitors for Bldg 1 and 2	$ 1,018,000
Furniture, Fixtures & Non-Clinical Equipment	Miscellaneous General - Trinity Signage - 2054	Facilities SL, Engineering Department # 35100	$ 600,000
Facilities	Facilities & Infrastructure	Fairbanks Energy LED: Energy Audit SFHMC, RHHCT, JMMC	$ 766,961
IT	New maintenance management system	New maintenance management system	$ 756,950
IT	IT system	Replacment of the treatment planning system; Pinncle and transition to Raytstation.	$ 500,000
Clinical	Philips Medical System		$ 885,970
Planning, Design & Construction	Renovation of oncology units	Renovate 8-1, 8-1a (donor funded)	$ 2,599,759
Planning, Design & Construction	Renovation of oncology units	Renovate 8-2	$ 675,000
		Sub-total projects >$500,000	**$ 11,085,776.00**

1000 Asylum Street
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November 30, 2016

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410 Capitol Avenue
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P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended September 30, 2016

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost savings opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Interest expense savings for the twelve months ended September 30, 2016 was $2.5 million with $2.0 million being realized in the six month period ended September 30, 2016 due to an interest rate rebate from system office received in June 2016 for approximately $1.0 million.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This was an overall decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. The benefit related to this change was $621,000 for the six month period ended 9/30/2016.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans, Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis

recognized an annual benefit in pension expense of $4.2 million for the twelve month period ended September 30, 2016. For the period from April 1, 2016 to September 30, 2016, the realized benefit was $2.9 million.

Since the last report provide to OHCA on May 31st, Saint Francis transitioned to the Trinity Health Group Purchasing Organization, HPG. This has resulted in supply chain savings of approximately $713,000 for the period April 1, 2016 to September 30, 2016. In addition, Saint Francis received HPG rebates of approximately $214,000 in September 2016. In addition to the pricing benefits realized under the HPG agreement, the Supply Chain leadership has been identifying contracts at Saint Francis that can be shifted to Trinity contracts which will also result in incremental savings in FY 2017.

As Saint Francis benefits from Trinity Health's pricing arrangements with vendors, we have also realized $1.2 million in cost savings for capital information technology relating to Epic hardware in the twelve months ended September 30, 2016. Operating expense savings relating to information technology was $53,000 for the six month period ended September 30, 2016.

There were no cost savings specific to Trinity Health – New England, Inc. (formerly known as Saint Francis *Care*, Inc.) as there are no operating expenses currently within this entity.

Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2016-9/30/2016

LINE	DESCRIPTION	Savings 4/1/2016-9/30/2016 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,921
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$927
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$1,953
H.	Malpractice Insurance Cost	$621
I.	Utilities	
J.	Business Expenses (insurance and IT)	$141
K.	Other Operating Expense	
	Total savings 10/1-3/31	$6,563

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$76,694,000	$22,557,000	($54,137,000)	-71%
2	Short Term Investments	$9,418,000	$33,338,000	$23,920,000	254%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$65,284,000	$67,940,000	$2,656,000	4%
4	Current Assets Whose Use is Limited for Current Liabilities	$1,521,000	$0	($1,521,000)	-100%
5	Due From Affiliates	$4,864,000	$47,485,000	$42,621,000	876%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$9,701,000	$8,912,000	($789,000)	-8%
8	Prepaid Expenses	$8,457,000	$4,378,000	($4,079,000)	-48%
9	Other Current Assets	$2,211,000	$2,134,000	($77,000)	-3%
	Total Current Assets	**$178,150,000**	**$186,744,000**	**$8,594,000**	**5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$48,893,000	$51,025,000	$2,132,000	4%
2	Board Designated for Capital Acquisition	$26,070,000	$27,789,000	$1,719,000	7%
3	Funds Held in Escrow	$817,000	$0	($817,000)	-100%
4	Other Noncurrent Assets Whose Use is Limited	($1,521,000)	$0	$1,521,000	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$74,259,000**	**$78,814,000**	**$4,555,000**	**6%**
5	Interest in Net Assets of Foundation	$9,394,000	$11,681,000	$2,287,000	24%
6	Long Term Investments	$25,350,000	$20,027,000	($5,323,000)	-21%
7	Other Noncurrent Assets	$7,117,000	$12,802,000	$5,685,000	80%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$873,910,000	$418,811,000	($455,099,000)	-52%
2	Less: Accumulated Depreciation	$427,558,000	$43,734,000	($383,824,000)	-90%
	Property, Plant and Equipment, Net	**$446,352,000**	**$375,077,000**	**($71,275,000)**	**-16%**
3	Construction in Progress	$8,411,000	$14,907,000	$6,496,000	77%
	Total Net Fixed Assets	**$454,763,000**	**$389,984,000**	**($64,779,000)**	**-14%**
	Total Assets	**$749,033,000**	**$700,052,000**	**($48,981,000)**	**-7%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$36,361,000	$24,750,000	($11,611,000)	-32%
2	Salaries, Wages and Payroll Taxes	$33,492,000	$35,638,000	$2,146,000	6%

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$12,528,000	$13,400,000	$872,000	7%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,298,000	$6,926,000	($372,000)	-5%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$6,680,000	$5,962,000	($718,000)	-11%
	Total Current Liabilities	**$96,359,000**	**$86,676,000**	**($9,683,000)**	**-10%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$244,154,000	$237,731,000	($6,423,000)	-3%
2	Notes Payable (Net of Current Portion)	$0	$0	$0	0%
	Total Long Term Debt	**$244,154,000**	**$237,731,000**	**($6,423,000)**	**-3%**
3	Accrued Pension Liability	$234,591,000	$226,613,000	($7,978,000)	-3%
4	Other Long Term Liabilities	$43,991,000	$15,130,000	($28,861,000)	-66%
	Total Long Term Liabilities	**$522,736,000**	**$479,474,000**	**($43,262,000)**	**-8%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$52,342,000	$49,025,000	($3,317,000)	-6%
2	Temporarily Restricted Net Assets	$24,417,000	$29,566,000	$5,149,000	21%
3	Permanently Restricted Net Assets	$53,179,000	$55,311,000	$2,132,000	4%
	Total Net Assets	**$129,938,000**	**$133,902,000**	**$3,964,000**	**3%**
	Total Liabilities and Net Assets	**$749,033,000**	**$700,052,000**	**($48,981,000)**	**-7%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,104,370,392	$2,252,204,000	$147,833,608	7%
2	Less: Allowances	$1,420,599,391	$1,498,710,000	$78,110,609	5%
3	Less: Charity Care	$13,558,599	$8,463,000	($5,095,599)	-38%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$670,212,402**	**$745,031,000**	**$74,818,598**	**11%**
5	Provision for Bad Debts	$20,980,833	$14,575,000	($6,405,833)	-31%
	Net Patient Service Revenue less provision for bad debts	**$649,231,569**	**$730,456,000**	**$81,224,431**	**13%**
6	Other Operating Revenue	$31,281,747	$38,574,000	$7,292,253	23%
7	Net Assets Released from Restrictions	$4,156,122	$3,397,000	($759,122)	-18%
	Total Operating Revenue	**$684,669,438**	**$772,427,000**	**$87,757,562**	**13%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,621,228	$258,412,000	$790,772	0%
2	Fringe Benefits	$68,082,765	$63,421,000	($4,661,765)	-7%
3	Physicians Fees	$47,535,764	$52,062,000	$4,526,236	10%
4	Supplies and Drugs	$99,464,711	$115,390,000	$15,925,289	16%
5	Depreciation and Amortization	$37,713,710	$44,179,000	$6,465,290	17%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$11,151,596	$8,115,000	($3,036,596)	-27%
8	Malpractice Insurance Cost	$10,303,205	$8,753,000	($1,550,205)	-15%
9	Other Operating Expenses	$149,739,353	$211,691,000	$61,951,647	41%
	Total Operating Expenses	**$681,612,332**	**$762,023,000**	**$80,410,668**	**12%**
	Income/(Loss) From Operations	**$3,057,106**	**$10,404,000**	**$7,346,894**	**240%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	($2,527,631)	$6,882,000	$9,409,631	-372%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($17,532,605)	($4,960,000)	$12,572,605	-72%
	Total Non-Operating Revenue	**($20,060,236)**	**$1,922,000**	**$21,982,236**	**-110%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($17,003,130)**	**$12,326,000**	**$29,329,130**	**-172%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($17,003,130)**	**$12,326,000**	**$29,329,130**	**-172%**
	Principal Payments	$8,785,000	$0	($8,785,000)	-100%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$102,071,000	$54,842,000	($47,229,000)	-46%
2	Short Term Investments	$33,496,000	$43,685,000	$10,189,000	30%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$77,445,000	$78,467,000	$1,022,000	1%
4	Current Assets Whose Use is Limited for Current Liabilities	$1,521,000	$0	($1,521,000)	-100%
5	Due From Affiliates	$3,400,000	$30,984,000	$27,584,000	811%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$9,701,000	$8,912,000	($789,000)	-8%
8	Prepaid Expenses	$7,851,000	$4,819,000	($3,032,000)	-39%
9	Other Current Assets	$6,745,000	$5,743,000	($1,002,000)	-15%
	Total Current Assets	**$242,230,000**	**$227,452,000**	**($14,778,000)**	**-6%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$48,894,000	$51,025,000	$2,131,000	4%
2	Board Designated for Capital Acquisition	$27,242,000	$27,789,000	$547,000	2%
3	Funds Held in Escrow	$43,133,000	$0	($43,133,000)	-100%
4	Other Noncurrent Assets Whose Use is Limited	($1,521,000)	$0	$1,521,000	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$117,748,000**	**$78,814,000**	**($38,934,000)**	**-33%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$25,097,000	$22,193,000	($2,904,000)	-12%
7	Other Noncurrent Assets	$15,864,000	$41,494,000	$25,630,000	162%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$912,915,000	$429,833,000	($483,082,000)	-53%
2	Less: Accumulated Depreciation	$454,078,000	$45,381,000	($408,697,000)	($1)
	Property, Plant and Equipment, Net	**$458,837,000**	**$384,452,000**	**($74,385,000)**	**-16%**
3	Construction in Progress	$8,411,000	$14,931,000	$6,520,000	78%
	Total Net Fixed Assets	**$467,248,000**	**$399,383,000**	**($67,865,000)**	**-15%**
	Total Assets	**$868,187,000**	**$769,336,000**	**($98,851,000)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$41,686,000	$30,149,000	($11,537,000)	-28%
2	Salaries, Wages and Payroll Taxes	$51,151,000	$57,548,000	$6,397,000	13%
3	Due To Third Party Payers	$13,630,000	$15,584,000	$1,954,000	14%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,298,000	$7,292,000	($6,000)	0%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$8,658,000	$6,583,000	($2,075,000)	-24%
	Total Current Liabilities	**$122,423,000**	**$117,156,000**	**($5,267,000)**	**-4%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$244,154,000	$255,276,000	$11,122,000	5%
2	Notes Payable (Net of Current Portion)	$0	$0	$0	0%
	Total Long Term Debt	**$244,154,000**	**$255,276,000**	**$11,122,000**	**5%**
3	Accrued Pension Liability	$276,965,000	$230,820,000	($46,145,000)	-17%
4	Other Long Term Liabilities	$43,991,000	$18,208,000	($25,783,000)	-59%
	Total Long Term Liabilities	**$565,110,000**	**$504,304,000**	**($60,806,000)**	**-11%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$101,295,000	$61,336,000	($39,959,000)	-39%
2	Temporarily Restricted Net Assets	$26,180,000	$31,229,000	$5,049,000	19%
3	Permanently Restricted Net Assets	$53,179,000	$55,311,000	$2,132,000	4%
	Total Net Assets	**$180,654,000**	**$147,876,000**	**($32,778,000)**	**-18%**
	Total Liabilities and Net Assets	**$868,187,000**	**$769,336,000**	**($98,851,000)**	**-11%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,433,798,000	$2,622,172,000	$188,374,000	8%
2	Less: Allowances	$1,621,115,000	$1,728,774,000	$107,659,000	7%
3	Less: Charity Care	$14,331,000	$9,009,000	($5,322,000)	-37%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$798,352,000**	**$884,389,000**	**$86,037,000**	**11%**
5	Provision for Bad Debts	$25,600,000	$18,334,000	($7,266,000)	-28%
	Net Patient Service Revenue less provision for bad debts	**$772,752,000**	**$866,055,000**	**$93,303,000**	**12%**
6	Other Operating Revenue	$38,303,000	$49,826,000	$11,523,000	30%
7	Net Assets Released from Restrictions	$10,911,000	$7,952,000	($2,959,000)	-27%
	Total Operating Revenue	**$821,966,000**	**$923,833,000**	**$101,867,000**	**12%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$378,595,000	$402,540,000	$23,945,000	6%
2	Fringe Benefits	$86,980,000	$86,331,000	($649,000)	-1%
3	Physicians Fees	$24,836,000	$28,805,000	$3,969,000	16%
4	Supplies and Drugs	$119,805,000	$137,840,000	$18,035,000	15%
5	Depreciation and Amortization	$39,696,000	$45,487,000	$5,791,000	15%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$11,152,000	$8,116,000	($3,036,000)	-27%
8	Malpractice Insurance Cost	$6,887,000	$12,151,000	$5,264,000	76%
9	Other Operating Expenses	$148,043,000	$201,439,000	$53,396,000	36%
	Total Operating Expenses	**$815,994,000**	**$922,709,000**	**$106,715,000**	**13%**
	Income/(Loss) From Operations	**$5,972,000**	**$1,124,000**	**($4,848,000)**	**-81%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	($2,530,000)	$5,904,000	$8,434,000	-333%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($17,533,000)	($4,960,000)	$12,573,000	-72%
	Total Non-Operating Revenue	**($20,063,000)**	**$944,000**	**$21,007,000**	**-105%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($14,091,000)**	**$2,068,000**	**$16,159,000**	**-115%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$58,589,000	$58,589,000	0%
	Total Other Adjustments	**$0**	**$58,589,000**	**$58,589,000**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($14,091,000)**	**$60,657,000**	**$74,748,000**	**-530%**

TRINITY HEALTH - NEW ENGLAND, INC.
(FORMERLY SAINT FRANCIS *CARE* , INC.)
CONSOLIDATED STATEMENT OF CASH FLOW

		Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$**	**60,657,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**45,487,000**
Bad debts		**18,334,000**
Increase in assets held in trust by others		**(2,131,000)**
Increase in accrued pension liability		**(46,145,000)**
Decrease in other long term liabilities		**(25,783,000)**
Purchase accounting		**(30,319,000)**
Transfer of swap to TH-NE		**(44,000,000)**
Other changes in net assets		**(19,116,000)**
Change in working capital, other than cash and cash equivalents		**(45,857,000)**
Net cash used in operating activities		**(88,873,000)**
Investing activities		
Purchase of property, plant and equipment, net		**(36,317,000)**
Purchase accounting, property, plant and equipment		**58,695,000**
Increase in investments		**(7,285,000)**
Increase in other noncurrent assets		**(25,630,000)**
Decrease in noncurrent assets whose use is limited		**41,065,000**
Net cash used in investing activities		**30,528,000**
Financing activities		
Issuance of long term debt		**18,000,000**
Principal payments on long-term debt		**(6,884,000)**
Net cash provided by financing activities		**11,116,000**
Net decrease in cash and cash equivalents		**(47,229,000)**
Cash and cash equivalents at beginning of period		**102,071,000**
Cash and cash equivalents at end of period	**$**	**54,842,000**

(FORMERLY SAINT FRANCIS *CARE* , INC.)
CONSOLIDATED STATEMENT OF CHANGES IN
COMPONENTS OF WORKING CAPITAL OTHER THAN
CASH AND CASH EQUIVALENTS

		Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$**	**1,521,000**
Accounts receivable--patients, net		**(19,356,000)**
Other current assets		**1,002,000**
Inventory of supplies		**789,000**
Prepaid expenses		**3,032,000**
Due from affiliated entities		**(27,584,000)**
		(40,596,000)
Changes in current liabilities:		
Accounts payable		**(11,537,000)**
Salary and wages, payroll taxes and amounts withheld from employees		**6,397,000**
Other current liabilities		**(2,075,000)**
Due to third party reimbursement agencies		**1,954,000**
		(5,261,000)
Changes in working capital other than cash and cash equivalents	**$**	**(45,857,000)**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

		Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$**	**12,326,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**44,179,000**
Bad debts		**14,575,000**
Increase in interest in Saint Francis Hospital and Medical Center Foundation		**(2,287,000)**
Increase in assets held in trust by others		**(2,132,000)**
Increase in accrued pension liability		**(7,978,000)**
Decrease in other long term liabilities		**(28,861,000)**
Other changes in net assets		**(8,362,000)**
Change in working capital, other than cash and cash equivalents		**(62,697,000)**
Net cash used in operating activities		**(41,237,000)**
Investing activities		
Purchase of property, plant and equipment, net		**(34,704,000)**
Purchase accounting, property, plant and equipment		**55,304,000**
Increase in investments		**(18,597,000)**
Increase in other noncurrent assets		**(5,685,000)**
Increase in noncurrent assets whose use is limited		**(2,423,000)**
Net cash used in investing activities		**(6,105,000)**
Financing activities		
Principal payments on long-term debt		**(6,795,000)**
Net cash used in financing activities		**(6,795,000)**
Net decrease in cash and cash equivalents		**(54,137,000)**
Cash and cash equivalents at beginning of period		**76,694,000**
Cash and cash equivalents at end of period	**$**	**22,557,000**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2016
Changes in current assets:	
Assets whose use is limited required for current liabilities	**$ 1,521,000**
Accounts receivable--patients, net	**(17,231,000)**
Other current assets	**77,000**
Inventory of supplies	**789,000**
Prepaid expenses	**4,079,000**
Due from affiliated entities	**(42,621,000)**
	(53,386,000)
Changes in current liabilities:	
Accounts payable	**(11,611,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**2,146,000**
Accrued expenses and interest payable	**(718,000)**
Due to third party reimbursement agencies	**872,000**
	(9,311,000)
Changes in working capital other than cash and cash equivalents	**$ (62,697,000)**

Attachment C

Saint Francis Hospital and Medical Center

	Sept 16 YTD	Sept 15 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.3%	0.4%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	8.1%	7.6%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.6%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.2	1.8	current assets/current liabilites
Days Cash on Hand	42.6	63.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	33.9	36.7	net ar/net patient ser rev(after bd)/days in yr
Average Payment Period	44.1	54.6	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	182.7%	193.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization	64.0%	65.3%	LTD/LTD+net assets
Unrestricted Cash to Debt	34.2%	44.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.3	1.3	EBIT/Interest expense
Debt Service Coverage Ratio	4.2 x	2.8 x	(Net income+int+depr)/(st debt+int exp)
Equity Financing Ratio	19.1%	17.3%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 10,404	$ 3,057	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 12,326	$ (17,003)	Net gain(loss)
EBITDA	$ 62,698	$ 51,923	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 55,895	$ 86,112	from cons bs
Net Working Capital	$ 100,068	$ 81,791	current assets-current liabilities
Unrestricted Assets	$ 49,025	$ 52,342	from cons bs

Attachment C

Trinity Health - New England (Hartford)

		Sept 16 YTD		Sept 15 YTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin		0.1%		0.7%	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		5.9%		6.9%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		0.7%		1.1%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		1.9		2.0	current assets/current liabilites
Days Cash on Hand		52.6		76.5	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables		33.1		36.6	net ar/net patient ser rev/days in yr
Average Payment Period		48.7		57.6	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		177.6%		139.2%	total debt/total equity(net assets)
Long-term Debt to Capitalization		63.3%		57.5%	LTD/LTD+net assets
Unrestricted Cash to Debt		0.5		0.6	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		1.1		1.5	EBIT/Interest expense
Debt Service Coverage Ratio		3.6 x		3.1 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		19.2%		20.8%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations	$	1,124	$	5,972	Net income(loss) from operations
Revenue Over/(Under) Expense	$	60,657 *	$	(14,091)	Net gain(loss)
EBITDA	$	54,727	$	56,820	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	98,527	$	135,567	from cons bs
Net Working Capital	$	110,296	$	119,807	current assets-current liabilities
Unrestricted Assets	$	61,336	$	101,295	from cons bs

* includes puchase accounting goodwill adjustment

Attachment C

Trinity Health - New England (Hartford)

	Sept 16 YTD	Sept 15 YTD	Explanation
D. Additional Statistics			YTD net patient revenue increased $93.3M, Operating expenses increased $106.7M due to costs of drugs and medical supplies, professional fees for EPIC support, merger due diligence, JMMC acquisition and purchase accounting including
Income(Loss) from Operations	1,124	5,972	depreciation and SFMG's increased loss of ($5.4M).
Revenue Over/(Under) Expense	60,657	(14,091)	Purchase accounting goodwill adjustment of $58.6 million. Swap activity of $15.5M for year end Sept 2015. SWAP transferred on 10/1 to Trinity Health.
EBITDA	54,727	56,820	YTD net patient revenue increased $93.3M, Operating expenses increased $106.7M due to costs of drugs and medical supplies, professional fees for EPIC support, merger due diligence, JMMC acquisition and purchase accounting including depreciation and SFMG's increased loss of ($5.4M).
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	98,527	135,567	Decrease in a/p ($11.5M); increase in due from affiliates $27.5M; funds expended for tail liablility $8.5M; JMMC purchase $2.3M; SWAP and debt termination expenses.
Net Working Capital	110,296	119,807	Decrease in cash and cash equivalents ($37M), decrease in a/p ($11.5M).
Unrestricted Assets	61,336	101,295	Change in PPE ($74M) due to purchase accounting adjustments; Increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Saint Francis Hospital

	Sept 16 YTD	Sept 15 YTD	
D. Additional Statistics			YTD net patient revenue increased $87M. Operating expenses increased $80M due to costs of drugs and medical supplies,
Income(Loss) from Operations	10,404	3,057	professional fees for EPIC support, nurse registry fees, merger due diligence, JMMC acquisiton and purchase accounting adjustments including depreciation.
Revenue Over/(Under) Expense	12,326	(17,003)	Swap activity of ($15.5M) for year end Sept 2015. SWAP transferred on 10/1 to Trinity Health.
EBITDA	62,698	51,923	YTD net patient revenue increased $87M. Operating expenses increased $80M due to costs of drugs and medical supplies, professional fees for EPIC support, nurse registry fees, merger due diligence, JMMC acquisiton and purchase accounting adjustments including depreciation.
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	55,895	86,112	Decrease in a/p ($11.6M), increase in due from affiliates $42.6M
Net Working Capital	100,068	81,791	Decrease in cash and cash equivelents ($30M), decrease in a/p ($11.6M), increase in due from affiliates $42.6M.
Unrestricted Assets	49,025	52,342	YTD income $10.4M; Change in PPE ($71M) due to purchase accounting adjustments; Increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity

Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Mrs. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Item #9 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to JMMC and JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

> *a) A list of planned capital expenditures with detailed descriptions and associated estimated costs; and b) A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and c) Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by JMMC's Chief Financial Officer.*

Since the approval of the Certificate of Need, Johnson has been in the process of developing the capital budget for FY 2017 (July 1, 2016 through June 30, 2017).

For the period April 1, 2016 through September 30, 2016, Johnson incurred capital expenditures of $1.1 million (See **Attachment A**). As previously reported, Trinity Health – New England (formerly known as Saint Francis *Care,* Inc.*)* and Johnson accelerated the timing of the implementation of the Epic electronic medical record system. The total capital cost of this system implementation relating to Johnson was approximately $6.8 million, which was paid by Saint Francis Hospital and Medical Center and ultimately structured as a capital lease to Johnson. Annual capital lease payments from Johnson to Saint Francis Hospital and Medical Center total $960,000 annually for seven years, $480,000 for the six month period ended September 30, which has been included in the capital expenditure report attached.

The FY 2017-FY2020 preliminary capital budget for Johnson (see **Attachment B**) was developed as part of the Trinity Health-New England's capital and operating budget processes as well as the current strategic financial planning process for the fiscal years 2018-2020. While capital projects are inventoried and identified during the strategic planning process, the actual expenditure for FY 2017, 2018 and 2019 will likely be $1.5 million, $3.0 million and $3.0 million, respectively. Individual items on Johnson's capital request will be continuously evaluated as we are constantly assessing the strategic needs of the facilities.

Johnson Memorial Hospital/Johnson Memorial Medical Center
New Acquisition Jan - Sept 16
Stipulation # 9 Attachment A

Row Labels	Sum of ORIGINAL COST
1/1/2016	**$ 102,509**
AccuDose Door Lock	$ 50,603
MRI Portico work	$ 31,904
software	$ 13,053
(blank)	$ 6,949
2/1/2016	**$ 40,656**
HD LED CD monitor/stand/basket	$ 14,260
JSC humidity & temp control	$ 26,396
3/1/2016	**$ 43,475**
AccuDose Door Lock	$ 7,425
analog video monitor syste -icu	$ 4,987
Endo cleaning station	$ 7,312
JSC humidity & temp control	$ 4,695
pneumatic Tube system	$ 10,276
upgrad to hum/temp controls	$ 8,780
4/1/2016	**$ 55,385**
Anesthesia monitors- lease buyout	$ 12,000
Psych room renovations	$ 19,825
renov for steris washer/sink,counter	$ 11,900
Steris/Amsco Washer	$ 11,660
5/1/2016	**$ 111,352**
Centricity Perinatal Intrapartum System	$ 86,343
Cystoscope equipment	$ 25,009
6/1/2016	**$ 279,465**
EPIQ 7G Ultrasound System	$ 259,640
Psych room renovations	$ 19,825
7/1/2016	**$ 23,496**
Endo cleaning station	$ 17,061
LF-DP Tracheal Intubation Fib rscope	$ 6,435
8/1/2016	**$ 119,998**
Kawneed series alum doors	$ 7,750
PeopleSoft Licenses	$ 112,248
Grand Total	**$ 776,335**

Epic Capital Lease	$	720,000
Total Capital Expenditures including Lease 1/1-9/30	$	1,496,335
Total Capital Expenditures including Lease 4/1-9/30	$	1,069,696

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Plant Operations (8060)	Electrical upgrades - Phase One (FY18= $600k, FY19=$100k)	1		460,909	239,091		
Plant Operations (8060)	Kitchen Exhaust System	1		235,797			
Radiology (7240)	Digital Radiology room - remove old equip, install	1	R	210,000			
Nursing Admin (6010)	R Series ALC biphasic ZOLL Defibrillators (11 defibrillators)	1	R	208,611			
Plant Operations (8060)	Paving Visitor Parking Lot	2	R	126,165			
Plant Operations (8060)	Patient Room windows - recalk for blurry			50,000			
Pharmacy (7330)	Guardrails Service contract for Alaris IV pumps	1	R	72,000			
Plant Operations (8060)	Repairs to main Entrance Canopy	1		65,418			
Plant Operations (8060)	Uranium System	1		35,000			
Radiology (7240)	Raometeric - one for JSC & JMH	1	N	18,000			
Pharmacy (7330)	3-card reader controller Locks (2 Stfd, 1 Enf)	1	N	10,000			
Plant Operations (8060)	Remove & install new Fire Hydrant	1		8,100			
Pharmacy (7330)	IV room @ JMH	1	N		500,000		
Radiology (7240)	Digital Mammography upgrad 2D @ JSC and Digital @JMH	1	R		430,000		
Radiology (7240)	R&F Digital room - remove old equip, install	1	R		$369,750		
Pharmacy (7330)	AcuDose Equipment for OR suites @ JSC OR suites	1	N	-	274,001		
Radiology (7240)	GE OEC C-Arm	2	R		200,000		
Ultrasound (7280)	Ultrasound room & removal of old u/s equip	1	R		135,395		
Ultrasound (7280)	Philips EPIQ 7 Diamond Select System	1	R		118,000		
Plant Operations (8060)	Boiler,Energy Saving Controls/Hawk system	1	R		125,915		
Plant Operations (8060)	Paving Roadway, Loading Dock area, parking	2	R		$122,841		
Pharmacy (7330)	AcuDose Software Upgrade Connect	1	R		76,118		
Nursing Admin (6010)	Carefusion Alaris PCA modules, Unites, ETC02 modules	1	R		75,768		
Cardiolvascular (7250)	Cardiovascular Ultrasound Scanner	1	R		75,150		
Plant Operations (8060)	Bobcat for Snow removal & grounds work	2			$70,000		
Central Sterile Proc. (6760)	Getinge 733 sterilizer	1	N		69,636		
JSC (Surgery Ctr) (6600)	OR Surgical Lights in OR 1, 2 & 3	1	R		66,492		
Plant Operations (8060)	ABS - JMH OR/Pharmacy/Heat Exchanger	2			61,320		
Plant Operations (8060)	Lighting Protections: Main Bldg; BH; PH; & WWTP	2			$55,550		
Plant Operations (8060)	Truck	2			50,000		

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
JSC (Surgery Ctr) (6600)	Stryker Video Equipment Incl display & camera heads	2	R		40,101		
Enfield Phys Med (7093)	Mediware MediLinks OP CUL License	1	N		39,960		
Perioperative Svcs (6610)	Urology Instrumentation	1	R		34,000		
Nursing Admin (6010)	Carefusion Alaris syringe modules and software	2	R		33,252		
Nursing Admin (6010)	3 EZZ way 1000 lb ceiling lifts w continuous charge	2	N		32,262		
Plant Operations (8060)	Paint Boiler House Smoke Stack	2			$31,180		
Psychiatry (6070)	Psychiatric Safe Medical Beds - 5 beds @ $5,900	2	N		29,500		
CT Scan (7230)	ACR CT phantoms for JSC & JMH	1	N		26,000		
Plant Operations (8060)	I-Net Sysetm Upgrade	1			13,285		
Pharmacy (7330)	Camera Security System for pharm (4 Stfd, 2 Enf)	1	N		12,000		
Plant Operations (8060)	Fleet Guard Key System - control system	2			11,818		
Radiology (7240)	Stryker Stretcher - trauma - JMH	1	R		$9,100		
Plant Operations (8060)	Backup Myers Pump for Bed 6 WWTP	2			9,084		
Ultrasound (7280)	Stryker OB Stretcher for JSC	1	N		6,000		
Plant Operations (8060)	Install 9 bollards in front of Generator	1			$7,786		
	Carefusion					2,000,000	
	Pixis						
Nuclear Medicine (7300)	Siemens Symbia T6 Spect/CT camera	1	R			599,600	
CT Scan (7230)	Siemens Somatome Perspective 64 slice scanner	1	R			525,000	
Radiology (7240)	RadSpeed Auto Dr Radiographic Room	2	R			273,350	
Laboratory (7020)	Hematology replacemsnt (2) Sysmex XN2000 analyzers	2	R			173,918	
Same Day Surgury (6605)	GE patient monitors & Central station monitor	2	R			145,834	
Plant Operations (8060)	Hot Water System	3				130,000	
Laboratory (7020)	(2) ACL TOP 300 Coagulation analyzers	1	R			90,000	
Perioperative Svcs (6610)	Mammotome	1	N			$65,526	
Radiology (7240)	Bone Density (remove old equip, install)	3	R			65,000	
Central Sterile Proc. (6760)	Getinge 8668 Washer Disinfecter 12 Tray unit	3	N			55,598	
Plant Operations (8060)	Fuel duplex pump set	3				47,919	
Plant Operations (8060)	Medical Vacuum System	3				$31,997	
Respiratory Therapy (7400)	Maquet SERVO - 1 Universal Core	1	N			30,681	

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Cardiac Rehab (7590)	complete phase 3 of business plan for relocation	1	N			23,100	
Radiology (7240)	C-Arm Table	3	R			20,000	
Plant Operations (8060)	New Well Install #9 - LaFamboise	3				17,155	
Anesthesia (7370)	Glide Scope	1	R			$14,422	
CT Scan (7230)	Renovation of Ct area - stretcher, curtain, paint/floor		R			10,000	
Radiology (7240)	renovation of main xray viewing room		N			10,000	
Emergency Rm (6850)	Stryker Stretcher - Trauma/2 Big Wheel	1	N			9,405	
Post Anesthesia Care (6660	Transport Monitor	1	N	-		8,530	
Laboratory (7020)	Ortho Workstation for ID-MTS Gel Cards	1	N			7,060	
Central Sterile Proc. (6760)	Getinge Prep & Pack table	3	N			6,883	
Enfield Phys Med (7093)	NuStep Recumbent Cross Trainer w/oversized seat	2	R			6,670	
Laboratory (7020)	Hematology micro scope	1	R			$6,400	
CT Scan (7230)	Countertop Blanket Warmer		N			6,000	
Radiology (7240)	GE 9" Laser Aimer for OEC 9899 +C-Arm Part		N			6,000	
Enfield Phys Med (7093)	AC5000M Treadmill w handrails/wght cap of 550 lbs	3	R			4,972	
CT Scan (7230)	64 slice Ct Scanner with install & remove old equip,	2	R				$569,170
Plant Operations (8060)	Contingency - Emergency Repairs	3					500,000
Anesthesia (7370)	Anesthisia Machines	3	R				400,000
Plant Operations (8060)	Nirenberg - Generators	3					350,000
Grand Totals JMMC				$ 1,500,000	$ 3,450,355	$ 4,391,020	$ 1,819,170

Note: Based on current infrastructure issues at Johnson, the creation of a sewer system is expected over the next three years. The estimated costs for Johnson relating to this project is approximately $4.0 million. This amount is not included in the schedule above.

1000 Asylum Street
Hartford, CT 06105
860-714-6165

November 30, 2016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Mrs. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio Capone
Regional Vice President of
Business Development and Strategic Planning
claudio.capone@trinityhealth-ne.org

Enclosures

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2016

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health – New England, Inc. In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $49,000 for the six month period ended September 30, 2016.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million with savings realized for the six month period ended September 30, 2016 of $496,000, exclusive of one time tail coverage costs incurred as part of the transaction.

There have been significant efforts to centralize support functions across Trinity Health-New England including Finance, Revenue Cycle, and Information Systems. This has resulted in reduction of costs at Johnson of $315,000 for the six months ended September 30, 2016.

In addition, Johnson has benefited from the utilization of regional Legal Services and Compliance and Audit departments. The decrease in legal and auditing costs associated with this transition were $258,000 for the six month period ended September 30, 2016.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health-New England and Trinity Health in each of the areas identified above.

The above savings are offset by a regional allocation of $319,000 for the six month period included in other operating expenses in **Attachment A.**

Interest and insurance savings related to JMMC are included in the amounts described above. There are no additional cost savings within JMMC.

In addition to the synergies realized to date, Johnson is in the process of transitioning to the Trinity Total Rewards program for employee compensation and benefits. Johnson provided its employees with a 2% pay increase on September 1st. This was the first across the board, cost of living increase that Johnson has been able to give its employees since 2008. In addition, effective 1/1/2017, Johnson employees will be participating in Trinity Health's defined contribution plan which provides for a core employer contribution for all employees and matching contributions funded bi-weekly for those employees who make deferrals into the plan.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. These cost savings will be reported when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining Trinity Health – New England, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. Areas of clinical quality improvement have been in decreased Sepsis rates, decreased readmission rates and notices of serious safety events were marginal.

Also, Johnson's average daily census during the months of September and October have been two of the higher months since prior to filing for bankruptcy.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The

required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2016-9/30/2016

LINE	DESCRIPTION	Savings 4/1/2016-9/30/2016 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$315
B.	Fringe Benefits (workers comp)	$101
C.	Contractual Labor Fees	$0
D.	Medical Supplies and Pharmaceutical Cost	$30
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$49
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$395
K.	Other Operating Expense	($61)
	Total savings 1/1-3/31	$829

JOHNSON MEMORIAL HOSPITAL					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
LINE	DESCRIPTION	FY 2015 ACTUAL	FY 2016 SEPTEMBER	AMOUNT DIFFERENCE	% DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,675,853	$0	($1,675,853)	-100%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$9,554,938	$0	($9,554,938)	-100%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,506,354	$0	($1,506,354)	-100%
8	Prepaid Expenses	$1,497,131	$0	($1,497,131)	-100%
9	Other Current Assets	$329,908	$0	($329,908)	-100%
	Total Current Assets	**$14,564,184**	**$0**	**($14,564,184)**	**-100%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$3,425,921	$0	($3,425,921)	-100%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$224,917	$0	($224,917)	-100%
4	Other Noncurrent Assets Whose Use is Limited	$843,587	$0	($843,587)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$4,494,425**	**$0**	**($4,494,425)**	**-100%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,467,074	$0	($3,467,074)	-100%
7	Other Noncurrent Assets	$8,986,456	$0	($8,986,456)	-100%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$66,495,422	$0	($66,495,422)	-100%
2	Less: Accumulated Depreciation	$45,821,926	$0	($45,821,926)	-100%
	Property, Plant and Equipment, Net	**$20,673,496**	**$0**	**($20,673,496)**	**-100%**
3	Construction in Progress	$0	$0	$0	0%
	Total Net Fixed Assets	**$20,673,496**	**$0**	**($20,673,496)**	**-100%**
	Total Assets	**$52,185,635**	**$0**	**($52,185,635)**	**-100%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$8,861,782	$0	($8,861,782)	-100%
2	Salaries, Wages and Payroll Taxes	$1,895,078	$0	($1,895,078)	-100%

JOHNSON MEMORIAL HOSPITAL					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$2,212,362	$0	($2,212,362)	-100%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$11,987,500	$0	($11,987,500)	-100%
6	Current Portion of Notes Payable	$838,274	$0	($838,274)	-100%
7	Other Current Liabilities	$10,142,734	$0	($10,142,734)	-100%
	Total Current Liabilities	**$35,937,730**	**$0**	**($35,937,730)**	**-100%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$4,572,057	$0	($4,572,057)	-100%
	Total Long Term Debt	**$4,572,057**	**$0**	**($4,572,057)**	**-100%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$7,433,424	$0	($7,433,424)	-100%
	Total Long Term Liabilities	**$12,005,481**	**$0**	**($12,005,481)**	**-100%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($498,600)	$0	$498,600	-100%
2	Temporarily Restricted Net Assets	$471,516	$0	($471,516)	-100%
3	Permanently Restricted Net Assets	$4,269,508	$0	($4,269,508)	-100%
	Total Net Assets	**$4,242,424**	**$0**	**($4,242,424)**	**-100%**
	Total Liabilities and Net Assets	**$52,185,635**	**$0**	**($52,185,635)**	**-100%**

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	JAN - SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$171,319,321	$0	($171,319,321)	-100%
2	Less: Allowances	$102,596,531	$0	($102,596,531)	-100%
3	Less: Charity Care	$221,056	$0	($221,056)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$68,501,734**	**$0**	**($68,501,734)**	**-100%**
5	Provision for Bad Debts	$3,114,000	$0	($3,114,000)	-100%
	Net Patient Service Revenue less provision for bad debts	**$65,387,734**	**$0**	**($65,387,734)**	**-100%**
6	Other Operating Revenue	$590,810	$0	($590,810)	-100%
7	Net Assets Released from Restrictions	$23,905	$0	($23,905)	-100%
	Total Operating Revenue	**$66,002,449**	**$0**	**($66,002,449)**	**-100%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$24,833,219	$0	($24,833,219)	-100%
2	Fringe Benefits	$6,111,895	$0	($6,111,895)	-100%
3	Physicians Fees	$4,050,496	$0	($4,050,496)	-100%
4	Supplies and Drugs	$10,665,670	$0	($10,665,670)	-100%
5	Depreciation and Amortization	$1,804,654	$0	($1,804,654)	-100%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$975,626	$0	($975,626)	-100%
8	Malpractice Insurance Cost	$1,058,521	$0	($1,058,521)	-100%
9	Other Operating Expenses	$20,739,982	$0	($20,739,982)	-100%
	Total Operating Expenses	**$70,240,063**	**$0**	**($70,240,063)**	**-100%**
	Income/(Loss) From Operations	**($4,237,614)**	**$0**	**$4,237,614**	**-100%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$228,556	$0	($228,556)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$0	$0	$0	0%
	Total Non-Operating Revenue	**$228,556**	**$0**	**($228,556)**	**-100%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($4,009,058)**	**$0**	**$4,009,058**	**-100%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($4,009,058)**	**$0**	**$4,009,058**	**-100%**
	Principal Payments	$184,222	$0	($184,222)	-100%

JOHNSON MEMORIAL MEDICAL CENTER, INC.

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,805,602	$0	($1,805,602)	-100%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$12,246,951	$0	($12,246,951)	-100%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,523,756	$0	($1,523,756)	-100%
8	Prepaid Expenses	$1,880,119	$0	($1,880,119)	-100%
9	Other Current Assets	$537,387	$0	($537,387)	-100%
	Total Current Assets	**$17,993,815**	**$0**	**($17,993,815)**	**-100%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$4,452,119	$0	($4,452,119)	-100%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$224,917	$0	($224,917)	-100%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$4,677,036**	**$0**	**($4,677,036)**	**-100%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,467,074	$0	($3,467,074)	-100%
7	Other Noncurrent Assets	$1,486,054	$0	($1,486,054)	-100%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$97,485,005	$0	($97,485,005)	-100%
2	Less: Accumulated Depreciation	$70,147,136	$0	($70,147,136)	($1)
	Property, Plant and Equipment, Net	**$27,337,869**	**$0**	**($27,337,869)**	**-100%**
3	Construction in Progress	$0	$0	$0	0%
	Total Net Fixed Assets	**$27,337,869**	**$0**	**($27,337,869)**	**-100%**
	Total Assets	**$54,961,848**	**$0**	**($54,961,848)**	**-100%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

JOHNSON MEMORIAL MEDICAL CENTER, INC.

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2016

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$12,652,911	$0	($12,652,911)	-100%
2	Salaries, Wages and Payroll Taxes	$2,677,952	$0	($2,677,952)	-100%
3	Due To Third Party Payers	$2,446,731	$0	($2,446,731)	-100%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$29,141,197	$0	($29,141,197)	-100%
6	Current Portion of Notes Payable	$838,274	$0	($838,274)	-100%
7	Other Current Liabilities	$11,243,011	$0	($11,243,011)	-100%
	Total Current Liabilities	**$59,000,076**	**$0**	**($59,000,076)**	**-100%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$4,572,057	$0	($4,572,057)	-100%
	Total Long Term Debt	**$4,572,057**	**$0**	**($4,572,057)**	**-100%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$4,932,692	$0	($4,932,692)	-100%
	Total Long Term Liabilities	**$9,504,749**	**$0**	**($9,504,749)**	**-100%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($18,535,995)	$0	$18,535,995	-100%
2	Temporarily Restricted Net Assets	$553,275	$0	($553,275)	-100%
3	Permanently Restricted Net Assets	$4,439,743	$0	($4,439,743)	-100%
	Total Net Assets	**($13,542,977)**	**$0**	**$13,542,977**	**-100%**
	Total Liabilities and Net Assets	**$54,961,848**	**$0**	**($54,961,848)**	**-100%**

JOHNSON MEMORIAL MEDICAL CENTER, INC.					
TWELVE MONTHS ACTUAL FILING					
FISCAL YEAR 2016					
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)	(3)	(5)	(6)
		FY 2015	FY 2016	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	JAN - SEPT	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$206,688,056	$0	($206,688,056)	-100%
2	Less: Allowances	$113,763,631	$0	($113,763,631)	-100%
3	Less: Charity Care	$221,056	$0	($221,056)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$92,703,369**	**$0**	**($92,703,369)**	**-100%**
5	Provision for Bad Debts	$3,470,135	$0	($3,470,135)	-100%
	Net Patient Service Revenue less provision for bad debts	**$89,233,234**	**$0**	**($89,233,234)**	**-100%**
6	Other Operating Revenue	$1,190,422	$0	($1,190,422)	-100%
7	Net Assets Released from Restrictions	$36,593	$0	($36,593)	-100%
	Total Operating Revenue	**$90,460,249**	**$0**	**($90,460,249)**	**-100%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$40,500,652	$0	($40,500,652)	-100%
2	Fringe Benefits	$10,064,877	$0	($10,064,877)	-100%
3	Physicians Fees	$4,050,496	$0	($4,050,496)	-100%
4	Supplies and Drugs	$12,485,965	$0	($12,485,965)	-100%
5	Depreciation and Amortization	$2,419,144	$0	($2,419,144)	-100%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$1,503,067	$0	($1,503,067)	-100%
8	Malpractice Insurance Cost	$1,056,331	$0	($1,056,331)	-100%
9	Other Operating Expenses	$25,211,129	$0	($25,211,129)	-100%
	Total Operating Expenses	**$97,291,661**	**$0**	**($97,291,661)**	**-100%**
	Income/(Loss) From Operations	**($6,831,412)**	**$0**	**$6,831,412**	**-100%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$159,517	$0	($159,517)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$69,138	$0	($69,138)	-100%
	Total Non-Operating Revenue	**$228,655**	**$0**	**($228,655)**	**-100%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($6,602,757)**	**$0**	**$6,602,757**	**-100%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($6,602,757)**	**$0**	**$6,602,757**	**-100%**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

		Nine months ended September 30, 2016
Operating activities and non-operating income		
Deficiency of revenues over expenses	**$**	**(3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**2,481,154**
Bad debts		**3,183,064**
Increase in pension and other accrued expenses		**801,386**
Other changes in net assets		**96,063**
Change in working capital, other than cash and cash equivalents		**2,513,860**
Net cash provided by operating activities		**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net		**(1,679,032)**
Decrease in long term investments		**269,872**
Increase in other assets		**(798,396)**
Net cash used in investing activities		**(2,207,556)**
Financing activities		
Principal payments on long-term debt		**(819,824)**
Net cash used in financing activities		**(819,824)**
Net increase in cash and cash equivalents		**2,059,069**
Cash and cash equivalents at beginning of period		**-**
Cash and cash equivalents at end of period	**$**	**2,059,069**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

		Nine months ended September 30, 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$**	**208,225**
Accounts receivable--patients, net		**(13,228,768)**
Other current assets		**(3,413,454)**
Inventory of supplies		**63,398**
Prepaid expenses		**719,973**
		(15,650,626)
Changes in current liabilities:		
Accounts payable		**(4,509,604)**
Salary and wages, payroll taxes and amounts withheld from employees		**1,886,309**
Due to affiliates		**22,551,291**
Other current liabilities		**(573,651)**
Due to third party reimbursement agencies		**(1,189,859)**
		18,164,486
Changes in working capital other than cash and cash equivalents	**$**	**2,513,860**

Attachment B

JOHNSON MEMORIAL HOSPITAL
CONSOLIDATED STATEMENT OF CASH FLOW

		September 30 2016
Operating activities and non-operating income		
Deficiency of revenues over expenses	**$**	**(3,473,942)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization		**2,839,922**
Bad debts		**2,385,036**
Decrease in pension and other accrued expenses		**(1,889,312)**
Other changes in net assets		**(160,459)**
Change in working capital, other than cash and cash equivalents		**5,287,169**
Net cash provided by operating activities		**4,988,414**
Investing activities		
Purchase of property, plant and equipment, net		**(2,002,371)**
Decrease in long term investments		**269,872**
Decrease in other assets		**(805,530)**
Net cash used in investing activities		**(2,538,029)**
Financing activities		
Principal payments on long-term debt		**(754,213)**
Net cash used in financing activities		**(754,213)**
Net increase in cash and cash equivalents		**1,696,172**
Cash and cash equivalents at beginning of period		**-**
Cash and cash equivalents at end of period	**$**	**1,696,172**

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

		September 30 2016
Assets whose use is limited required for current liabilities	**$**	**208,225**
Accounts receivable--patients, net		**(11,271,174)**
Other current assets		**(3,309,083)**
Inventory of supplies		**63,398**
Prepaid expenses		**694,257**
		(13,614,377)
Changes in current liabilities:		
Accounts payable		**(4,954,229)**
Salary and wages, payroll taxes and amounts withheld from employees		**1,658,036**
Due to affiliates		**23,268,975**
Other current liabilities		**98,693**
Due to third party reimbursement agencies		**(1,169,929)**
		18,901,546
Changes in working capital other than cash and cash equivalents	**$**	**5,287,169**

Attachment C

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 16 YTD*	Sept 15 YTD	Comments
A. Operating Performance:			
Operating Margin	(6.8%)	(6.4%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	(0.4%)	(2.2%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	2.3%	1.8%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.4	current assets/current liabilites
Days Cash on Hand	9.6	8.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	100.8	53.3	net ar/net patient ser rev/days in yr
Average Payment Period	183.7	191.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	(399.0%)	410.1%	total debt/total equity(net assets)
Long-term Debt to Capitalization	135.5%	51.9%	LTD/LTD+net assets
Unrestricted Cash to Debt	7.6%	9.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	(4.0)	(3.3)	EBIT/Interest expense
Debt Service Coverage Ratio	(0.12)	(0.11)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	(11.3%)	8.1%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ (3,227)	$ (4,238)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ (3,474)	$ (4,009)	Net gain(loss)
EBIDA	$ (195)	$ (1,458)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,696	$ 1,676	from bs
Net Working Capital	$ (7,781)	$ (21,374)	current assets-current liabilities
Unrestricted Assets	$ (6,169)	$ (499)	from bs

*1/1/-9/30/16

Attachment C

Johnson Memorial Medical Center, Inc.

Monthly Financial Measurement/Indicators		Sept 16 YTD*		Sept 15 YTD	Comments
A. Operating Performance:					
Operating Margin		(7.4%)		(7.6%)	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		(1.2%)		(3.2%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		2.5%		1.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		0.8		0.30	current assets/current liabilites
Days Cash on Hand		10.8		6.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables		106.2		50.1	net ar/net patient ser rev/days in yr
Average Payment Period		175.0		227.0	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		3117.9%		(255.1%)	total debt/total equity(net assets)
Long-term Debt to Capitalization		96.8%		(51.0%)	LTD/LTD+net assets
Unrestricted Cash to Debt		9.2%		5.2%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		(4.8)		(3.5)	EBIT/Interest expense
Debt Service Coverage Ratio		(0.4)		(0.1)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		1.3%		-24.6%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations	$	(3,744)	$	(6,831)	Net income(loss) from operations
Revenue Over/(Under) Expense	$	(3,989)	$	(6,603)	Net gain(loss)
EBIDA	$	(617)	$	(2,909)	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	2,059	$	1,806	from bs
Net Working Capital	$	(5,887)	$	(41,006)	current assets-current liabilities
Unrestricted Assets	$	84	$	(18,536)	from bs

*1/1-9/30/16

Olejarz, Barbara

From: Cotto, Carmen
Sent: Monday, February 06, 2017 10:22 AM
To: Olejarz, Barbara
Cc: Roberts, Karen
Subject: FW: Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)

Hi Barbara,

Please add the email below in the paper/pdf file for the following docket number's record: TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045).

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Cotto, Carmen
Sent: Thursday, February 02, 2017 4:23 PM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org)
Cc: Roberts, Karen
Subject: Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)

Hi Claudio,

Below you will see some compliance follow up questions or issues for the Applicants to address.

Please note that this email is a follow up to your compliance submissions, for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045), on December 1, 2016 and that the separate issue related to the coordination of future filings due dates for the three Dockets will be discussed at a future time.

Please submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You can contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thanks,
Carmen

For Trinity Health-New England (TH-NE) (Docket#15-31979)

1. Condition#8 - Applicants provided the Hospital's Community Health Needs Assessment (CHNA) Implementation Strategy Plan. In reference to this plan, provide a narrative describing how the plan will address the community health needs listed on its CHNA.

2. Condition#14 - Applicants provided a written report that describes the culturally and linguistically appropriate services that are currently in place at the Hospital. In reference to this report, indicate how the Hospital utilized the standards published by the U.S. Department of Health and Human Services' Office of Minority Health as guidance for the development of the report.

For Johnson Memorial (Docket#15-32002)

3. Condition#8 - Provide Johnson Memorial's CHNA Implementation Strategy Plan and a narrative describing how the plan will address the community health needs listed on its CHNA. If not available, indicate when it will be available.

4. Condition#10 - Explain the zero amounts submitted as part of the Balance Sheet and Statement of Operations for the 1/1/16 to 9/30/16 period and resubmit the documents to include the missing data.

5. Condition#14 - Applicants did not provide a written report describing activities meeting culturally and linguistically appropriate services at the Johnson Memorial Hospital. Provide the missing report and indicate how the standards published by the U.S. Department of Health and Human Services' Office of Minority Health were used as guidance for the development of the report.

For Saint Mary's Hospital (Docket#15-32045)

6. Condition#4 - Elaborate on how Saint Mary's Hospital utilized the Healthy Connecticut State Health Improvement Plan data and priorities, as well as any applicable community health improvement plan issued by local health departments in the service area, as the starting point for the development of the Hospital's CHNA.

7. Condition#14 - Provide the status of the Community Representative selected to serve as a voting member of the Hospital's Board of Directors. Provide a narrative describing the selection process.

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Thursday, March 09, 2017 11:35 PM
To: User, OHCA; Cotto, Carmen
Cc: Janeanne C. Lubin-Szafranski; Schneider, Jennifer
Subject: TH-NE Responses to Conditions for CONs 15_32045 15_31979 15_32002
Attachments: Responses to Conditions 15_32045 15_31979 15_32002.pdf

Hello Carmen,

In response to your February 2, 2017 email titled, " Compliance Follow up issues for TH-NE (DN:15-31979), Johnson (DN:15-32002) and ST Mary's (DN:15-32045)," attached are Trinity Health - New England's responses.

Please feel free to contact me with any questions you may have.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning and Business Development
Trinity Health - New England

claudio.capone@trinityhealth-ne.org
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Trinity Health
New England

Carmen Cotto
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue
MS#13HCA
P.O Box 340308
Hartford, CT 06134-0308

March 9, 2017

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England; Docket Number 15-31979-CON for Trinity Health – New England; Docket Number 15-32002-CON for Johnson Memorial

Dear Ms. Cotto:

In accordance with the TH-NE compliance follow up questions for the above CONs, enclosed is responses for each of the conditions noted.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

For Trinity Health-New England (TH-NE) (Docket#15-31979)

1. **Condition#8 - Applicants provided the Hospital's Community Health Needs Assessment (CHNA) Implementation Strategy Plan. In reference to this plan, provide a narrative describing how the plan will address the community health needs listed on its CHNA.**

   The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13, 2016. The 5 significant health needs identified in the Community Conversation Meeting included: Community Safety & Violence, Housing Insecurity, Family & Social Support, Employment & Poverty, Access to Care.

   In addition to findings from the Community Conversations, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services. And finally for the city of Hartford in particular the issues of unstable housing; violence; employment and education were all identified as significant needs.

   - **See Attachment 1** for the Implementation Strategy for Saint Francis Hospital and Medical Center
   - **See Attachment 2** for the Implementation Strategy for Mount Sinai Rehabilitation Hospital

2. **Condition#14 - Applicants provided a written report that describes the culturally and linguistically appropriate services that are currently in place at the Hospital. In reference to this report, indicate how the Hospital utilized the standards published by the U.S. Department of Health and Human Services' Office of Minority Health as guidance for the development of the report.**

   The Curtis D. Robinson Center for Health Equity was given the work of developing a comprehensive Language Services Program. In the last two years, phase I of the program has successfully been implemented around Saint Francis Medical Center, the Mount Sinai campus and our various off-site locations. The services include language

interpretation and translation of documents to assist patients who are deaf or hard of hearing, have a speech disability or have limited English skills. These resources are referred to as the 3 +1 Options and include telephone-based interpreting, video remote interpreting (VRI-MARTTI), in-person interpreting/ ASL or CDI and written translation of vital and non-vital documents. Each department on both campuses is equipped with dual handset phones for telephonic interpretation and there are 40 Video Remote Interpreter (VRI) - Martti carts on site on both campuses that are readily used by staff for patients and their companions. Off-site St. Francis Care physicians and non-St. Francis Care physician offices and affiliates who are on site also have access to language resources.

In addition to the already established Language Services Program, phase II of the program, the Qualified Medical Interpreter training, began shortly after. The training entails identifying qualified bi-lingual/multilingual staff to become Qualified Medical Interpreters. Thus far, there have been 4 cohorts to complete this training and a total of 30 staff members to successfully complete and pass the course. To partake in this training, each staff had to successfully pass the language proficiency assessment administered by Interpreters and Translators, Inc., (iTi), and complete the 40 hour in person training offered once a week for 5 weeks on-site at the Center for Health Equity. The training includes content such as the foundation of the profession of community interpreting, the code of ethics and standards of practice, culture and mediation and guides interpreters on how to intervene when a communication barrier arrives.

Most recently, based on OCR's Section 1557, all language service notices and signage were updated to include the top 15 Non-English Spoken languages indicating to all patients that language resources were available to them at no cost. As for the current state of the program, there are on-going in-person educational trainings for all medical staff, volunteers, learners and contractors. A newly revised annual health stream training for all current employees and new employees is available and there has been an update and enhancement of Martti software and distribution system. The medical interpreter training for qualified staff will continue as well bi-annually.

For Johnson Memorial (Docket#15-32002)

3. **Condition#8 - Provide Johnson Memorial's CHNA Implementation Strategy Plan and a narrative describing how the plan will address the community health needs listed on its CHNA. If not available, indicate when it will be available.**

The CHNA conducted in 2016 identified significant health needs within the JMH community. Those needs were then prioritized based on a Community Conversation and focus groups with key stakeholders held during 2016. Significant health needs identified, in order of priority include: Healthy Behavior Change Diet & Exercise, Substance Abuse & Tobacco Use, Access to health care, and Poverty & Employment.

- **See Attachment 3** for the Implementation Strategy for Johnson Memorial

4. **<u>Condition#10</u> - Explain the zero amounts submitted as part of the Balance Sheet and Statement of Operations for the 1/1/16 to 9/30/16 period and resubmit the documents to include the missing data.**

   Please reference the response for the above condition in the email submission from Mary Lou Rosadini on February 13, 2017.

5. **<u>Condition#14</u> - Applicants did not provide a written report describing activities meeting culturally and linguistically appropriate services at the Johnson Memorial Hospital. Provide the missing report and indicate how the standards published by the U.S. Department of Health and Human Services' Office of Minority Health were used as guidance for the development of the report.**

   Johnson Memorial Hospital has adopted the work done at Saint Francis Hospital and Medical Center as it relates to linguistically appropriate services. The Curtis D. Robinson Center for Health Equity was given the work of developing a comprehensive Language Services Program. In the last two years, Phase I of the program has successfully been implemented at Johnson Memorial Hospital and its off-site locations. The services include language interpretation and translation of documents to assist patients who are deaf or hard of hearing, have a speech disability or have limited English skills. These resources are referred to as the 3 +1 Options and include telephone-based interpreting, video remote interpreting (VRI-MARTTI), in-person interpreting/ ASL or CDI and written translation of vital and non-vital documents. Each department on both campuses is equipped with dual handset phones for telephonic interpretation and there are 40 Video Remote Interpreter (VRI) - Martti carts on site on both campuses that are readily used by staff for patients and their companions. Off-site Johnson Memorial Hospital physicians and non- Johnson Memorial Hospital physician offices and affiliates who are on site also have access to language resources.

   Most recently, based on OCR's Section 1557, all language service notices and signage were updated to include the top 15 Non-English Spoken languages indicating to all

patients that language resources were available to them at no cost. As for the current state of the program, there are on-going in-person educational trainings for all medical staff, volunteers, learners and contractors. A newly revised annual health stream training for all current employees and new employees is available and there has been an update and enhancement of Martti software and distribution system. The medical interpreter training for qualified staff will continue as well bi-annually. There is an annual review of language access needs of the patient population served by Johnson Memorial Hospital.

For Saint Mary's Hospital (Docket#15-32045)

6. **Condition#4 - Elaborate on how Saint Mary's Hospital utilized the Healthy Connecticut State Health Improvement Plan data and priorities, as well as any applicable community health improvement plan issued by local health departments in the service area, as the starting point for the development of the Hospital's CHNA.**

   In collaboration with the Greater Waterbury Health Improvement Partnership (GWHIP), Saint Mary's Hospital along with five additional organizations, including the City of Waterbury Health Department utilized the Healthy Connecticut State Health Improvement Plan (2014). The data and priorities within the Healthy Connecticut State Health Improvement Plan were observed and the roadmap to complete the stated initiatives were noted throughout the community-wide coalition. In addition, the Greater Waterbury Health Improvement Partnership used the data to ensure that the service areas that are included within the 2016 Community Health Needs Assessment will benefit and see successful results in advancing Connecticut's population health. With the seven focus areas that were touched on in the Healthy Connecticut State Health Improvement Plan, the Greater Waterbury Health Improvement Partnership plans to address the following five which all fall into the addressed priorities of the state including: Access to Care, Mental Health/Substance Abuse, Chronic Disease, Tobacco Use and Asthma, and Health Communications. It should be noted that Saint Mary's Hospital 2016 Community Health Needs Assessment Implementation Plan was filed publicly on Wednesday, February 15, 2017 and shows the direct alignment with the Healthy Connecticut State Health Improvement Plan.

   - **See Attachment 4** for the Saint Mary's Hospital 2016 Community Health Needs Assessment Implementation Plan

7. **<u>Condition#14</u> - Provide the status of the Community Representative selected to serve as a voting member of the Hospital's Board of Directors. Provide a narrative describing the selection process.**

   As required in the Agreed Settlement, the Saint Mary's Hospital Board Chair, and the President, consulted Waterbury Mayor Neil O'Leary in August 2016 regarding the appointment of a community representative to serve as a voting member of the Saint Mary's Hospital Board. The Mayor recommended Attorney Linda Wihbey, Corporation Counsel for the City of Waterbury, as a person who will effectively and without bias, consider matters affecting quality and safety, and the health needs of the local community. Attorney Whibey's appointment was approved by the Saint Mary's and the Trinity Health-New England boards in September 2016.

ATTACHMENT 1

Saint Francis Hospital and Medical Center
Community Health Needs Assessment Implementation Strategy
2016 - 2019

Saint Francis Hospital and Medical Center (SFHMC) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on June 22, 2016. SFHMC performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community members, and various community organizations.

The complete CHNA report is available electronically at http://www.saintfranciscare.com/About_Us/Hospital_Publications.aspx or printed copies are available by emailing: plarivie@stfranciscare.org

Hospital Information and Mission Statement

MISSION
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CORE VALUES

- **Reverence:**
  We honor the sacredness and dignity of every person.
- **Commitment to Those who are Poor:**
  We stand with and serve those who are poor, especially those most vulnerable.
- **Justice:**
  We foster right relationships to promote the common well, including sustainability of Earth.
- **Stewardship:**
  We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- **Integrity:**
  We are faithful to who we say we are.

Saint Francis Hospital and Medical Center's service area comprises urban, suburban, and rural communities that together form a rich mixture of highly diverse races and ethnicities, and a wide range of socioeconomic categories.

Its primary service area includes 25 towns and corresponds largely with the greater Hartford region. The Hospital's secondary service area includes 28 towns largely to the west and south of the primary service area. These towns are more rural, and their needs are very different than those of the city of Hartford, which has more than three times as many patients discharged from Saint Francis than any other municipality.

A comparison of population density, household income, and median age reveal that these communities are anything but uniform, and the resources for addressing concerns and needs of their residents differ as well. Yet, many of the health issues they face are similar; obesity, diabetes, heart disease, and behavioral health were all mentioned by the leaders of health districts who serve these towns.

Hartford's population of 125,000 is composed of all races and myriad ethnicities. Some 44 percent of its citizens are Hispanic/Latino and 35 percent Black/African American, with subgroups that include refugees and immigrants

from Africa, Eastern Europe, the Middle East, Asia, South America, and the West Indies. Additionally, 22 percent of the total population in Hartford is foreign born, bringing a tremendous diversity to the city.

The city is proportionately younger than the rest of the state as well as the country; over 25 percent of its residents are under age 17 and only 9 percent are over age 65, compared to 22 percent and 15 percent respectively for the state as a whole. This affects age-related health issues, such as some forms of cancer, violence, and accidental injury.

Hartford is a city of vibrant neighborhoods – 17 distinct neighborhoods, to be exact – with a variety of housing stock ranging from high-rise downtown luxury apartments and condos to historic houses to single-family homes and a variety of rental options. The city's many neighborhoods are supported by a roster of community organizations that focus on issues, such as economic development, housing, and assimilation of new immigrants, education, and historic preservation.

Health Needs of the Community

The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13th. The 5 significant health needs identified in the Community Conversation Meeting included:

Community Safety & Violence	• Ranked as the highest priority at the Community Conversation Meeting • 54% of Hartford residents said it was not safe to walk in their neighborhood
Housing Insecurity	• Home ownership is only 26% in Hartford • 32% of renters are subsidized
Family & Social Support	• 59% of residents said they "do not trust neighbors" • Limited support for positive health behaviors
Employment & Poverty	• Only 59% of Hartford residents are regularly employed • 79% of Hartford household are below adequate income levels
Access to Care	• 50% of residents are worried about the cost of care • 23% of residents don't have a regular doctor

In addition to findings from the Community Conversation, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services. And finally for the city of Hartford in particular the issues of unstable housing; violence; employment and education were all identified as significant needs.

Hospital Implementation Strategy

Saint Francis Hospital and Medical Center's resources, mission, goals, strategic priorities and the significant health needs identified through the most recent CHNA process were all considered during the development of the hospital's Implementation Strategy. The Hospital's Well Being 360 (WB360) project, which was selected to be part of Trinity Health's national Transforming Communities Initiative, combines resources from the hospital, community groups, state and local government departments, and national resources to create a collaborative approach to improving the health of the community.

The WB360 project will address identified health needs by:

- Engaging in an **anchor institution** approach designed to impact high-need neighborhoods in Hartford's North End by addressing social determinants of health.

- Encouraging health behavior change through the support of evidence-based programs in the areas of **diet, exercise** and support for changes in **tobacco policy.**

- Testing a model of clinical care that integrates the healthcare delivery system with social support programs, with a specific focus on **behavioral health.**

- Transforming the physical environment through support of local partner agencies working to improve **housing, neighborhood safety** and opportunities for **physical activity.**

Transforming Communities - Well Being 360
The Implementation Strategy to be executed by SFHMC is called the Well Being 360 and includes an investment from the hospital as well as leveraged resources from the Trinity Health system and community partnering agencies. The work will include the development of a coalition with the goal of bringing all of the varied resources to the table for collective impact approaches to address the social determinants of health that are so significant in the city's poorest neighborhoods. The work will involve community investments based on a set of principles agreed upon by the WB360 Steering Committee. Well Being 360 investments will be made based on:

1. Alignment with CHNA identified needs and health system priorities;
2. Strong evidence of effectiveness in achieving targeted outcomes;
3. Capacity to implement solutions and build coalition with community partners and residents;
4. Value of the investment (impact per dollar invested) in achieving short-term and longer-term outcomes; and
5. Sustainability of solution after initial investment.

Significant Health Needs That Will Not be Addressed:
SFHMC acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. SFHMC will not take action on the following health needs:

- Housing Insecurity
  The Partnership for Stronger Communities has done significant work in the area of homelessness prevention and is taking the lead on this community health issue. We will collaborate with them on this work but expect to serve in a supportive role.

- Employment and Poverty:
  The health collaborative being developed by our partner Community Solutions in the North End of Hartford will serve as the leader for this work.

- Sexual Activity:
  The City of Hartford has a strong program in this area and this issue was rated as a low priority in our Community Conversation.

- Air and Water Quality:
  Although these were mentioned by community members as a concern, the City of Harford and its partner agencies are focused on this work.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending in September of 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Community Safety and Violence		
CHNA REFERENCE PAGE:	P. 23	**PRIORITIZATION #:** 1	
BRIEF DESCRIPTION OF NEED: Excessive violence, concerns for safety in neighborhoods, and lack of opportunities for diversion.			
GOAL: Create partnerships with four local organizations to increase diversionary options for youth and improve the physical environment to promote safety.			
OBJECTIVE: Work with local community agencies and develop a work group on violence prevention.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Develop a coalition work group focused on violence prevention. 2. Provide monetary support to community agencies. 3. Identify best practices for small cities.			
ANTICIPATED IMPACT OF THESE ACTIONS: 1. Stronger collaborative relationships. 2. Strengthened community agencies focused on violence prevention. 3. By next survey, increased feelings of safety.			
PLAN TO EVALUATE THE IMPACT: DataHaven Survey – Comparison of 2019 and 2016. Community Conversations			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coalition Leadership Monetary Support of Partners.			
COLLABORATIVE PARTNERS: Hartford Communities That Care Community Solutions Peace Builders			

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Family and Social Support (Healthy Behaviors - Diet & Exercise)		
CHNA REFERENCE PAGE:	20	**PRIORITIZATION #:** 2a	

BRIEF DESCRIPTION OF NEED:

High rates of Obesity, Diabetes and Heart Disease are impacted significantly by behaviors. In Hartford, the Obesity rate is 33% and those impacted by diabetes in a survey completed by the CDRCHE included 68% of participants.

GOAL:
Provide easily accessible programs that focus on healthy eating and active living behaviors that result in positive health changes.

OBJECTIVE:
Engage 120 participants in the first year of the programs and establish and on-going, sustainable process for providing the programs to those residents with the highest need.

Collaborate with the Complete Streets Committee to move forward on changes to the environment that encourage physical activity.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify appropriate partners to provide the programs in community settings.
Develop a referral system to identify high need patients and provide high quality actionable referrals.
Invest in programs to they can be provide free of charge to patients and residents in need of these support services.

ANTICIPATED IMPACT OF THESE ACTIONS:
Better relationships with program participants.
Increase knowledge and healthy behaviors for those who complete the programs.
Improved long term health outcomes.

PLAN TO EVALUATE THE IMPACT:
Pre and post-test screening of knowledge and behavior.
Development of Patient Advisory Board to support on-going engagement.
In year 3 - Review of health records for up to 10% of program participants.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
Well Being 360 Investment
In-Kind support for data collection and program evaluation.

COLLABORATIVE PARTNERS:
YMCA - Diabetes Prevention Program
Live Well – Diabetes Prevention Program
Cooking Matters – Food Access and Budgeting Program
City of Hartford Complete Streets Committee

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Family and Social Support (Resources for Tobacco Use)		
CHNA REFERENCE PAGE:	21	**PRIORITIZATION** #: 2b	
BRIEF DESCRIPTION OF NEED: Tobacco Use in Connecticut is at 16%, well above the Healthy People 2020 goal of 12%. Rates among Connecticut youth are similar to adults, which highlight an opportunity to have an impact on health outcomes.			
GOAL: Make changes to tobacco policy at the state and local level to support tobacco cessation. Focus on youth smoking rates			
OBJECTIVE: Collaborate with a statewide coalition to encourage tobacco use cessation. Develop relationships with clinical leaders to improve tobacco screening and referral.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Identify local resources for patients and others to access. Engage youth and others in messaging about tobacco cessation.			
ANTICIPATED IMPACT OF THESE ACTIONS: Change in legislation that makes it harder to market e-cigarettes. Improved messaging on campus about the prohibition of tobacco products of all kinds including e-cigarettes. Decreased uptake of smoking among young adults.			
PLAN TO EVALUATE THE IMPACT: Review legislative accomplishments for the past 12 months. Identify signage changes regarding tobacco free campus. Examine rates of smoking in young adults.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Well Being 360 Investment Changes in campus wide signage			
COLLABORATIVE PARTNERS: MATCH Coalition Regional Health Ministry Sites: Johnson Memorial; Mount Sinai; Saint Mary's; Mercy Medical Center			

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	SFHMC		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare (Focus on Behavioral Health)		
CHNA REFERENCE PAGE:	23	**PRIORITIZATION #:** 3	
BRIEF DESCRIPTION OF NEED: Access to behavioral health services is limited for patients on Medicaid and over 40 of survey respondents said they feel down sometimes or often. According to the report, My Brothers Keeper 06120, trauma and behavioral health impact academic performance; criminal behavior; ability to develop trusting relationships; employment and drug use.			
GOAL: Develop and pilot an electronic referral system embedded in the EMR that enables providers to make referrals and monitor follow through.			
OBJECTIVE: Enroll 300 patients in the program and monitor the delivery of support services to those referred.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Partner with community agency to develop the project. Collaborate with home care agencies who provide in home clinical and social support services. Monitor outcomes of the project to determine feasibility of large scale implementation.			
ANTICIPATED IMPACT OF THESE ACTIONS: Improved satisfaction for patients enrolled in the project. Decreased need for urgent care services. Increased stability in patient's lives.			
PLAN TO EVALUATE THE IMPACT: Survey of patient satisfaction. Monitor use of ED services. Interview sample of patients about quality of life changes.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coordination of project activities in safety net clinics. Collaboration with partner agencies in meetings; problem solving and monitoring of program outcomes. Support for grant funding applications.			
COLLABORATIVE PARTNERS: Community Solutions Ambulatory Care Clinic Home Care Agency (yet to be identified) Intercommunity; Wheeler Clinic			

Adoption of Implementation Strategy

On 1-20-17 the Mission Committee of the Board of Directors for Saint Francis Hospital & Medical Center met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment. Upon review, the Mission Committee recommends approval by the full Board of Directors at their next meeting of this Implementation Strategy and the related budget.

Name & Title SVP Mission Integration Trinity Health - New England

01/25/2017
Date

ATTACHMENT 2

Mount Sinai Rehabilitation Hospital
Community Health Needs Assessment Implementation Strategy
2016 - 2019

Mount Sinai Hospital (MSRH) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on September 30, 2016. SFHMC performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community members, and various community organizations.

The complete CHNA report is available electronically at http://www.saintfranciscare.com/About_Us/Hospital_Publications.aspx or printed copies are available by emailing: plarivie@stfranciscare.org

Hospital Information and Mission Statement

MISSION
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CORE VALUES

- **Reverence**:
  We honor the sacredness and dignity of every person.

- **Commitment to Those who are Poor:**
  We stand with and serve those who are poor, especially those most vulnerable.

- **Justice:**
  We foster right relationships to promote the common well, including sustainability of Earth.

- **Stewardship:**
  We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

- **Integrity:**
  We are faithful to who we say we are.

Mount Sinai Rehabilitation Hospital's service area comprises urban, suburban, and rural communities that together form a rich mixture of highly diverse races and ethnicities, and a wide range of socioeconomic categories. Most patients seen have disabilities; spinal cord injuries; brain injuries; and complications due to stroke. Stroke is the most common reason for hospitalization and risk factors include diabetes, obesity and smoking; all of which were identified in the CHNA as priorities. Additionally, patients with Multiple Sclerosis and other neurological diseases are frequently served by Mount Sinai Rehabilitation Hospital. Trauma due to gunshots, violence, motor vehicle accidents and other accidents are also common; as are amputees who suffer with diabetes. Mount Sinai serves to treat the consequences of these conditions with primary treatment and engages in secondary prevention through education, community outreach and programs to reduce incidence.

Mount Sinai serves the entire State of Connecticut. Its primary service area includes 25 towns and corresponds largely with the greater Hartford region. The Hospital's secondary service area includes 28 towns largely to the west and south of the primary service area.

Hartford's population of 125,000 is composed of all races and myriad ethnicities. Some 44 percent of its citizens are Hispanic/Latino and 35 percent Black/African American, with subgroups that include refugees and immigrants from Africa, Eastern Europe, the Middle East, Asia, South America, and the West Indies. Additionally, 22 percent of the total population in Hartford is foreign born, bringing a tremendous diversity to the city. The city is proportionately younger than the rest of the state as well as the country; over 25 percent of its residents are under age 17 and only 9 percent are over age 65, compared to 22 percent and 15 percent respectively for the state as a whole. This affects age-related health issues, such as some forms of cancer, violence, and accidental injury. The MSRH has a special focus on veterans and on neurological illnesses especially multiple sclerosis

Health Needs of the Community

The CHNA conducted in 2016 identified 5 significant health needs within the Greater Hartford community. Those needs were then prioritized based on a Community Conversation Meeting that took place on September 13th. The 5 significant health needs identified in the Community Conversation Meeting included:

Community Safety & Violence	• Ranked as the highest priority at the Community Conversation Meeting • 54% of Hartford residents said it was not safe to walk in their neighborhood
Housing Insecurity	• Home ownership is only 26% in Hartford • 32% of renters are subsidized
Family & Social Support	• 59% of residents said they "do not trust neighbors" • Limited support for positive health behaviors
Employment & Poverty	• Only 59% of Hartford residents are regularly employed • 79% of Hartford household are below adequate income levels
Access to Care	• 50% of residents are worried about the cost of care • 23% of residents don't have a regular doctor

In addition to findings from the Community Conversation, the quantitative CHNA data identified other areas of need within the Hartford community and beyond. High rates of obesity, diabetes and heart disease are of concern for both residents and health professionals; tobacco use rates in Hartford are higher than national averages and are similar in adult and youth populations; concerns about access to healthcare are particularly acute for those in need of behavioral health services.

Hospital Implementation Strategy

Mount Sinai Rehabilitation Hospital's resources, mission, goals, strategic priorities and the significant health needs identified through the most recent CHNA process were all considered during the development of the hospital's Implementation Strategy.

The health priorities for the Mount Sinai Rehabilitation Hospital and the Mandell Center for Comprehensive Multiple Sclerosis Care include:

1. Access to comprehensive rehabilitation facilities (focus on Veterans)
2. Patient frustration with disjointed rehabilitation care
3. Lack of coordinated and comprehensive care for MS patients
4. Increased need for research to better understand MS treatment options

The Physical Medicine and Rehabilitation (PM&R) Service Line at Mount Sinai Rehabilitation Hospital strives to facilitate and enhance individual recovery, function, and optimal performance with an emphasis on those populations with impairments that either place them at risk or result in temporary and/or permanent disability.

It serves as a regional and national leader in the delivery of coordinated rehabilitation services providing;

2015

- Neurology
  - Neurologist 4 days/wk
  - PA Full time
  - Recruiting second neurologist
- Physiatry
- Urology
  - Urologist 1.5 days/wk
  - Urodynamics RN
  - Ultrasound tech
- Infusion Center
  - Infusion Nurse Full time
  - Per diem Infusion Nurses-2
  - Medical Assistant
- Case Management
- Skilled Therapy:
  - PT (3), OT (2), ST (1) –dedicated MS team
- Neuropsychology
- New Services
  - Pharmacy
  - Integrative Medicine(yoga, accupuncture)

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Rehabilitation Healthcare Services (focus on veterans)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 1	

BRIEF DESCRIPTION OF NEED:
Veterans are in need of support programs focusing on their unique set of needs.

GOAL:
Improve the resources, and increase the quality of the programs available for Veterans

OBJECTIVE:
Enhance the relationship with the Veterans Administration to provide high quality accessible rehabilitation services across the state to veterans in need of support.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Increase staff appropriately
- Establish referral coordinator program to facilitate proper patient transitions to MSRH
- Create educational/training programs

ANTICIPATED IMPACT OF THESE ACTIONS:
- Improve access of programs for Veterans
- Broaden array of resources
- Increase participation of Veterans in support programs

PLAN TO EVALUATE THE IMPACT:
- Patient Satisfaction Survey Responses
- Conversations with Veterans Administration Leadership
- Number of veterans participating in programs

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- Staffing for Outreach to the Veteran population
- Leadership participation at board level or committees with a focus on Healthcare for Veterans
- Amputee Informational series
- Health & Fitness Initiatives through Outpatient Services
- Community Outreach Programs including: Adaptive Rowing; Golfers in Motion; and others.

COLLABORATIVE PARTNERS:
1. Quinnipiac University
2. Department of Veterans Affairs

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Rehabilitative Services (continuity of rehabilitation services)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 2	

BRIEF DESCRIPTION OF NEED:
Provide comprehensive rehabilitation services to those who suffer from brain injury, stroke, heart disease and other chronic illness.

GOAL:
Enhance efficiency in recovery, community reintegration and secondary prevention.

OBJECTIVE:
Improve long-term functional and health status and improve the likelihood of independent living and a high quality of life

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Education and Training for rehabilitation professionals, patients, and the community
- Research and clinical innovation to advance in the field of rehabilitation medicine
- Advocacy in partnerships to ensure the needs of those with disabilities are recognized, understood, and addressed by policy makers

ANTICIPATED IMPACT OF THESE ACTIONS:
- Reduce the likelihood of complications, relapse, and/or re-hospitalizations
- Halt or slow the progression of primary and secondary disabilities (maintain functioning and prevent further deterioration)

PLAN TO EVALUATE THE IMPACT:
- Monitor discharge, transfers and readmissions rates
- Report on capability to manage patient population
- Outline set of added services

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- Powerful Tools For Caregivers
- Integrative Medicine- Acupuncture, massage on campus
- Monthly Stroke Survivors Support Group
- Spinal Cord injury Informational Series
- Community Outreach Programs including: Adaptive Rowing; Golfers in Motion and others

COLLABORATIVE PARTNERS:
- Acute Care Hospitals and Trauma Centers across the state
- Emergency Department staff
- CT State Department of Public Health
- Stoke Center at SFHMC

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 - 2019			
HOSPITAL FACILITY:	Mount Sinai Rehabilitation Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare (rehabilitation services for patients with MS)		
CHNA REFERENCE PAGE:	22	**PRIORITIZATION #:** 3 & 4	

BRIEF DESCRIPTION OF NEED:
Provide comprehensive interdisciplinary care for those with Multiple Sclerosis to achieve optimal outcomes.

GOAL:
Become Center of Excellence for MS. Provide high quality state of the art care to those suffering from Multiple Sclerosis. Expand community access for our Center of Excellence for MS.

OBJECTIVE:
- Expand services area reach beyond current primary service area.
- Increase partners in order to address disjointed care
- Advocate at the payor and legislative level regarding access to services

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
- Enhance the coordination of MS Care
- Improve research portfolio and numbers of patients involved in trials
- Integrate State of the art technologies to enhance clinical outcomes

ANTICIPATED IMPACT OF THESE ACTIONS:
- Value driven rehabilitation care across the continuum
- Work with partners to ensure the needs of those with MS are addressed by policymakers

PLAN TO EVALUATE THE IMPACT:
- Measure the development of innovative interdisciplinary care programs
- Increase in portfolio of new technology, trials and robotics (hyperbaric chamber treatment)
- Improved research infrastructure

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
- C.A.R.P. Community Adaptive Rowing Program
- Golfers in Motion and other Physical Therapy Programs
- Men's MS Support Group
- Patient Led Support Group for individuals with MS
- MS International Symposium Patient Day (Education, Resources, support for individuals with MS, families & clinicians)
- MS center facilitated Education Seminars for Patients with MS/families related to DMT options

COLLABORATIVE PARTNERS:
1. Multiple Sclerosis Society
2. Research Support
3 Mandell Family Foundation

Adoption of Implementation Strategy

On 1-24-17 the Mission Committee of the Board of Directors for Mount Sinai Rehabilitation Hospital met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment Upon review, the Mission Committee recommends approval by the full Board of Directors at their next meeting of this this Implementation Strategy and the related budget

Howard Orr 1/25/17

Howard Orr
Mount Sinai Rehabilitation Hospital
Board Chairman

Date

ATTACHMENT 3

Trinity Health – New England
Johnson Memorial Hospital
Community Health Needs Assessment Implementation Strategy
Fiscal years 2016-2019

Johnson Memorial Hospital (JMH) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on 2-7-17. JMH performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at www.jmmc.com or printed copies are available from Patricia Lariviere plarivie@stfranciscare.org

Hospital Information and Mission Statement

Mission

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values

Reverence
We honor the sacredness and dignity of every person.

Commitment to those who are poor
We stand with and serve those who are poor, especially those most vulnerable.

Justice
We foster right relationships to promote the common good, including sustainability of Earth.

Stewardship
We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity
We are faithful to who we say we are.

Johnson Memorial Hospital is a 92-bed hospital located in Stafford Springs Connecticut that has been an anchor institution in north central Connecticut for 104 years. The Hospital moved from its original location on East Street in Stafford Springs to its present location on Chestnut Hill Road in 1975. During the 1980s, few health care organizations throughout the United States were branching out by creating subsidiaries, and Johnson Memorial Hospital (JMH) was one of the first to bring this type of business structure to Connecticut. Early in the decade, Johnson Health Care, Johnson Development Fund and Wellcare joined Johnson Memorial Hospital under the Johnson Memorial Corporation umbrella. Soon after, the

organization opened Connecticut's first free-standing, hospital-affiliated outpatient surgery center, Johnson Surgery Center. In the intervening years, Johnson has continued expanding services to meet the community's needs. In September 2010, JMH emerged from Chapter 11 as an independent, community-based health care provider as it had been for nearly a century. In July of 2012, JMH and Saint Francis *Care* signed an Affiliation Agreement, resulting in a mutually beneficial relationship that has provided the community with a sustainable, high quality healthcare resource. As a result, JMH has experienced improved operations by all measures of financial performance.

In 2016, Johnson Memorial Hospital and the other Johnson entities became part of Trinity Health - New England, an integrated health care delivery system that is a member of Trinity Health, Livonia, MI, one of the largest multi-institutional Catholic health care delivery systems in the nation. Today, Johnson Memorial Hospital and Home & Community Health Services provide a continuum of health care services to those living and working in north central Connecticut and western Massachusetts.

Health Needs of the Community

The CHNA conducted in 2016 identified significant health needs within the JMH community. Those needs were then prioritized based on a Community Conversation and focus groups with key stakeholders held during 2016. Significant health needs identified, in order of priority include:

Healthy Behavior Change: Diet & Exercise	• 66% of JMH survey respondents are either overweight or obese • High Blood Pressure is the leading cause of hospitalization.
Substance Abuse & Tobacco Use	• Opioid use had increased significantly • 16% of CT adult smoke and youth rates are similar
Access to health care.	• 23% of residents indicate postponing care due to access. • Of those 56% said that cost was a significant factor.
Poverty and Employment	• Although the population is educated, employment opportunities are limited. • 12% of residents indicated the need to participate in food pantries due to limited income for food.

Hospital Implementation Strategy

JMH resources and overall alignment with the hospital's mission, goals and strategic priorities were taken into consideration of the significant health needs identified through the most recent CHNA process.

Significant health needs that will not be addressed

Johnson Memorial Hospital acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only

those health needs which it deemed most pressing, under-addressed, and within its ability to influence. JMH will not take action on the following community needs:

- **Poverty and lack of employment opportunities.**
- **Lack of public transportation resources.**

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Support for Healthy Behavior Change: Diet & Exercise		
CHNA REFERENCE PAGE:	Pages 15,17,18	**PRIORITIZATION #:** 2	

BRIEF DESCRIPTION OF NEED:

High rates of Obesity, Diabetes and Heart Disease are impacted significantly by behaviors. In the JMH service area 66% of residents are either overweight or obese. And high blood pressure is the most common reason for hospitalization.

GOAL:
Provide easily accessible programs that focus on healthy eating and active living behaviors that result in positive health changes.

OBJECTIVE:
Engage 60 participants in the first year of the programs and establish and on-going, sustainable process for providing the programs to those residents with the highest need.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify appropriate partners to provide the programs in community settings.
Develop a referral system to identify high need patients and provide high quality actionable referrals.
Invest in programs so they can be provide free of charge to patients and residents in need of these support services.

ANTICIPATED IMPACT OF THESE ACTIONS:
Better relationships with program participants.
Increase knowledge and healthy behaviors for those who complete the programs.
Improved long term health outcomes.

PLAN TO EVALUATE THE IMPACT:
Pre and post-test screening of knowledge and behavior for program participants.
In year 3 - Review of health records for up to 10% of program participants.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
In-Kind support for data collection and program evaluation.

COLLABORATIVE PARTNERS:
American Heart Association
Diabetes Prevention Programs

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Substance Abuse and Tobacco Use		
CHNA REFERENCE PAGE:	17	**PRIORITIZATION** #: 3	

BRIEF DESCRIPTION OF NEED:
Tobacco Use in Connecticut is at 16%, well above the Healthy People 2020 goal of 12%. Rates among Connecticut youth are similar to adults, which highlight an opportunity to have an impact on health outcomes.
Opioid use has increased significantly in the rural areas of the service area.

GOAL:
Make changes to tobacco policy at the state and local level to support tobacco cessation.
Engage programs that focus on youth smoking rates
Develop a set of substance abuse prevention and treatment resources.

OBJECTIVE:
Collaborate with a statewide coalition to encourage tobacco use cessation.
Develop relationships with clinical leaders to improve tobacco screening and referral.
Engage partners in development of resources for opioid abuse.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:
Identify local resources for patients and others to access.
Engage youth and others in messaging about tobacco cessation.

ANTICIPATED IMPACT OF THESE ACTIONS:
Change in legislation that makes it harder to market e-cigarettes.
Improved messaging on campus about the prohibition of tobacco products of all kinds including e-cigarettes.
Decreased uptake of smoking among young adults.
Identification and education of providers and others about resources to address substance abuse.

PLAN TO EVALUATE THE IMPACT:
Review legislative accomplishments for the past 12 months.
Identify signage changes regarding tobacco free campus.
Examine rates of smoking in young adults with Data Haven support.
Survey of providers and patients about knowledge of substance abuse resources.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
Changes in campus wide signage
In-Kind support for resource identification

COLLABORATIVE PARTNERS:
MATCH Coalition
Regional Health Ministry Sites: Johnson Memorial; Mount Sinai; Saint Mary's; Mercy Medical Center

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2016 – 2019			
HOSPITAL FACILITY:	Johnson Memorial Hospital		
CHNA SIGNIFICANT HEALTH NEED:	Access to Healthcare		
CHNA REFERENCE PAGE:	20	**PRIORITIZATION #: 1**	
BRIEF DESCRIPTION OF NEED: 23% of survey participants indicated they have postponed healthcare in the past 12 months because of limited access. The most common reason sited was cost with 56% of those who said the postponed care attributing cost to the reason for doing so.			
GOAL: Work to improve understanding of healthcare costs; improve enrollment in health insurance and decrease the numbers reporting that care is postponed due to access.			
OBJECTIVE: Enroll 100 patients in health insurance or programs or screen them for financial assistance for healthcare resources. Educate providers and patients about the resources available for those with limited income.			
ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: Partner with community agency to develop an outreach effort about health insurance resources and the importance of financial screening.			
ANTICIPATED IMPACT OF THESE ACTIONS: Improved satisfaction for patients and greater access to needed health resources. Increased stability in patient's lives.			
PLAN TO EVALUATE THE IMPACT: Survey of patient satisfaction. Measure of patient health insurance coverage.			
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: Coordination of financial screening resources from Saint Francis with Johnson staff. Staffing of educational programs about health resources in the community.			
COLLABORATIVE PARTNERS: **Saint Francis Hospital** **Financial Aid Counselors** **ACCESS Health CT**			

Adoption of Implementation Strategy

On 2-7-17 the Board of Directors for Johnson Memorial Hospital met to discuss the 2016-2019 Implementation Strategy for addressing the community health needs identified in the 2016 Community Health Needs Assessment. The Board adopted the plan and related budget and designated the chairman of the board to sign the documents for approval.

Patrick Mahon, Chairman

2/15/17
Date

ATTACHMENT 4

Saint Mary's Hospital
Community Health Needs Assessment

Implementation Plan 2016

Saint Mary's HOSPITAL

Exceptional care. Every patient. Every day.

2016 Community Health Needs Assessment Implementation Plan

Following the 2016 Community Health Needs Assessment, Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors at Saint Mary's Hospital. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the five priority areas are listed below.

I. Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

Key Indicators

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

Existing Programs

Hospital-Based Access to Care Programs

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2016, these advocates assisted 1,558 individuals in obtaining insurance coverage.
- In January 2014, Saint Mary's began the insurance and cost estimate program was implemented. Patients, who request an estimate, now receive a document that estimates the cost of care.
- Saint Mary's has a patient tracking system for its Same Day Surgery department as of September 2013.
- Saint Mary's has a comprehensive communication strategy to promote primary care and urgent care through direct patient education, community health events and marketing communications such as search engine optimization, online appointment booking and digital media strategies.
- Saint Mary's promotes the use of a patient's electronic health record as a means of providing access to patient's health information including medications, providers and office visits.
- In October 2016, Saint Mary's installed signage in multiple languages that educates patients and visitors to use our language and interpretation services.
- Saint Mary's is a partner in the Waterbury Health Access Program which improves access to high-quality medical care for uninsured and underinsured residents of Greater Waterbury.
- Saint Mary's Family Health Center and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have Medicaid. Thousands of patients receive services through these clinics.

Grant-Funded

- Saint Mary's has grant funding from the Connecticut Department of Public Health for The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP), which was formerly known as the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS). This program provides screening for breast, cervical and colorectal cancer and if a cancer is diagnosed through the grant, funds are available for treatment.
- As one of five hospitals in the state of Connecticut, Saint Mary's received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs (CYSHCN). This program develops care plans and provides healthcare regardless of income for children and youth with chronic physical and/or behavioral issues not only to Saint Mary's practices but to the community as well.

Initiatives

- Explore further options of care using the PUMP Club model (see section III., Healthy Lifestyles) of direct-to-care access.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care, Waterbury Health Access Program) for uninsured/underinsured and low income patients and families.
- Explore further development of nurse navigator programs to improve access to primary care and behavioral health.
- Evaluate need for additional mobile screening vehicles in the Greater Waterbury market
- Continue to enhance Autism-friendly space and training for emergency department providers

II. Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase mental health and substance abuse screening by primary care providers
- Increase number of points of access for referral to services

Key Indicators

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental or behavioral health.
- Length of stay in ED for mental or behavioral health patients.
- Number of ED referrals for mental or behavioral health care services.
- Number of patients who utilize outpatient behavioral health services.

Existing Programs

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 15, 637 patients were discharged from the unit. The average length of stay in the unit is 6.5 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,700 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2015, 13,254 ED patients had a primary or secondary diagnosis related to behavioral health. These patients represent 18% of total visits (71,762). The average length of stay for behavioral health patients in 2015 the ED was 33 hours or 1.4 days.
- In 2016, Saint Mary's implemented Enhanced Recovery After Surgery (ERAS), a program designed to reduce or eliminate the use of narcotics in surgery.

Initiatives

- Spearhead efforts to create and organize a Community Care Team focused on high risk behavioral health patients with efforts from the Greater Waterbury Health Improvement Partnership.
- Complete construction of Behavioral Health unit in the Emergency Department to better meet patient needs.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions, Association of Ambulatory Behavioral Health, and the Mental Health Association of Connecticut.
- Increase education and percentage of narcotic-free surgeries completed at Saint Mary's Hospital.
- Continue to evaluate use of telemedicine for mental and behavioral health.

III. Healthy Lifestyles (Obesity, Heart Disease, and Diabetes)

Goal: Reduce chronic health disease through awareness and education.

Objectives:

- Enact process to collect data within Physician Network Organization on patient Body Mass Index (BMI) levels.

Key Indicators

- Number of patients with a Body Mass Index (BMI) screening.
- Number of patients with a calculated Body Mass Index (BMI) of overweight or obese that were referred to additional care.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children who receive meals through the Health Nutrition Grant.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Percent of healthy options placed in vending machines on hospital campus.

Existing Programs

Hospital-Based Healthy Lifestyles Programs

- Saint Mary's offers inpatient nutritional counseling and a significantly expanded outpatient nutritional counseling services that provide support groups and education.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2015, 131 patients had bariatric surgery.
- Saint Mary's has expanded and enhanced Cardiac Rehabilitation wellness program.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a program titled Mindful by Sodexo that includes healthy and nutritious food options.
- Beginning in 2016, Saint Mary's now offers breastfeeding classes taught by a certified lactation consultant specifically for mothers returning to work.
- Saint Mary's was awarded a grant to pilot the American College of Cardiology Nurse Navigator Program in 2014. Since then, the pilot has expanded into the PUMP Club; this program provides patients with Congestive Heart Failure education and coordination of post-acute care services.
- In 2016, Saint Mary's Hospital achieved its Chest Pain Center Accreditation with Primary PCI and Resuscitation from the American College of Cardiology Accreditation Services (formerly Society of Cardiovascular Patient Care).
- In 2016, Saint Mary's added a new Diabetes and Endocrinology Center.

Grant-Funded

- Saint Mary's is also a grant recipient of the WISEWOMEN™ program which helps women understand and reduce their risk for heart disease and stroke by providing services and screenings to promote lasting heart healthy lifestyles.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.

Initiatives

- Evaluate ways to continue to improve meal choices and healthy vending options at the hospital.
- Enhance existing breast feeding policies and procedures through exploration of Baby Friendly designation.
- Continue to promote education about heart disease including preventions such as Early Heart Attack Care and Hands-Only CPR.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Explore potential to facilitate training for and hosting of American Diabetes Association's Live Well with Diabetes within the hospital network.

IV. Tobacco Use and Asthma

Goal: Become a leader in expanding our role with tobacco control to reduce illness, disability, and death related to tobacco use and secondhand smoke exposure. In addition, reduce the incidence and progression of asthma in the Greater Waterbury region.

Objectives:

- Following Connecticut Department of Public Health guidelines and Connecticut Hospital Association tools to reduce asthma hospitalizations and Emergency Department visits.
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase publicity of Saint Mary's tobacco and e-cigarette free environments.
- Enact process to collect data within Physician Network Organization on the percentage of adult patients screened for tobacco use and cessation intervention.

Key Indicators

- Number of patients that receive a tobacco screening.
- Number of patients who receive a smoking cessation referral.
- Number of patients who successfully complete smoking cessation counseling.
- Number of physicians participating in the Easy Breathing Program.

Existing Programs

- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.
- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- Continue to explore efforts Greater Waterbury Region Asthma Coalition and the statewide health improvement initiative by Connecticut Hospital Association.

Initiatives

- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.
- Support Regional Health Ministry in efforts on Tobacco 21, Smoke Free Movies and other tobacco control policies in the state of Connecticut
- Initiate and properly educate patients on Smoke Free Campuses including the use of E-cigarettes
- Upon implementation of new Electronic Health Record, report to Trinity Health System Office the number of patients screened for tobacco use and cessation intervention.
- Support Greater Waterbury Region Asthma Coalition in implementing Asthma Action Plan in Emergency Department.
- Increase education to patients regarding asthma triggers including poor air quality days and second-hand smoke.

V. Health Communications

Goal: As a member of the Greater Waterbury Health Improvement Partnership, Saint Mary's Hospital will be a leader in advancing the ability for quality health information and increase the target area's health literacy.

Objectives:

- Increase visibility of health and well-being programs in the Greater Waterbury community through various community tools and provider education
- Increase availability of Greater Waterbury Health Improvement Partnership reports and data

Key Indicators

- Number of people who engage in Greater Waterbury Health Improvement Partnership website and social media posts.

Existing Programs

- A communications workgroup has been formed within the Greater Waterbury Health Improvement Partnership.

Initiatives

- Assist with creation and promotion of Greater Waterbury Health Improvement Partnership website, social media and communication vehicles.

Appendix A: CHNA Implementation Plan Resources

Bridge to Success Community Partnership
Catholic Charities
Catholic Family Services
Chesprocott Health District
City of Waterbury
Community Health Centers, Inc.
Connecticut Community Foundation
End Hunger Connecticut
Family Services of Greater Waterbury
Greater Waterbury Health Improvement Partnership (GWHIP)
Harold Leever Regional Cancer Center
Healthcare without Harm
Local and national legislators
Malta House of Care
Neighborhood Housing Services of Waterbury
New Opportunities, Inc.
Pomperaug District Department of Health
Public and Private School Systems
StayWell Health Center, Inc.
Trinity Health
Trinity Health – New England
United Way of Greater Waterbury
Value Options
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Health Access Program
Waterbury Youth Services
Wellmore Behavioral Health

User, OHCA

From: Cotto, Carmen
Sent: Thursday, May 25, 2017 2:23 PM
To: Capone, Claudio
Cc: Roberts, Karen; User, OHCA
Subject: RE: Trinity Health -New England CON filing requirements

Hi Claudio,

We will get back to you on the matter of coordinating the due dates.

Meantime, please provide us with a reason for your request for an extension by no later than midday tomorrow, Friday, May 26, 2017.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Thursday, May 25, 2017 7:09 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Trinity Health -New England CON filing requirements

Hi Carmen…I spoke to Jennifer and Finance would like to keep the reporting on our current 6 months schedule October 1 – March 31st due May 31 and April-September due November 30. It should be the same for all TH-NE facilities.

That said, can we get a 2 week extension on our May 31st filing?

Thanks,

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 16, 2017 4:26 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio,

This is to follow up on our request below for feedback on our suggested wording to help coordinate the various required filings from Trinity Health-New England.

Last time we spoke you were waiting for Ms. Schneider's return from vacation to provide us with a feedback.

We need to hear from you prior to finalizing the wording in question.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
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Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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www.ct.gov/dph

From: Roberts, Karen
Sent: Friday, February 24, 2017 11:38 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio – the wording below is what OHCA staff is thinking will help to better coordinate the various required filings to OHCA from Trinity Health –New England for the three recent transfer of ownership agreed settlements. Before we have this put in an email from our Director, Kim Martone, please take a look and let us know if this will help TH-NE out with having less filing dates to hit for these three CONs. The yellow highlights show where the words "following the Closing Date" appear in the conditions and OHCA's clarifying statement appears then in Red/Bold. Thanks. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

I. Certain Agreed Upon Conditions from Docket Number 15-31979-CON, St. Francis/Trinity - CLOSING/TRANSACTION DATE WAS OCTOBER 1, 2015

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on SFCRHM's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, SFCRHM shall submit to OHCA its Capital Investment Plan detailing the proposed allocation of the $275 million capital investment commitment over the five-year period post-closing. The submitted plans shall account for the full $275M commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. SFCRHM shall submit written reports updating the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the Hospital's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by SFCRHM's Chief Financial Officer.

14. SFCRHM shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, SFCRHM shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual

Report. The written report shall be posted on SFCRHM Website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS NOVEMBER 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON NOVEMBER 30TH ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

II. Certain Agreed Upon Conditions from Docket Number 15-32002-CON, Johnson Memorial/Trinity - CLOSING/TRANSACTION DATE WAS JANUARY 1, 2016

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on New JMMC's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to New JMMC and New JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from New JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by New JMMC's Chief Financial Officer.

14. New JMMC and New JMH shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, New JMMC and New JMH shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual Report. The written report shall be posted on New JMMC website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS FEBRUARY 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON MAY 31ST ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

III. ***Certain Agreed Upon Conditions from Docket Number 15-32045-CON, St. Mary's/Trinity***
- CLOSING/TRANSACTION DATE WAS AUGUST 1, 2016

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL REMAINS DUE AT THIS TIME.

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and
    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL MAY BE FILED EACH MAY 31ST AND NOVEMBER 30TH AS SET FORTH IN CONDITION #8 AS REFERENCED WITHIN #7.

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

    In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    d. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

13. TH-NE shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, TH-NE shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, TH-NE shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, TH-NE shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, TH-NE shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 29.*

THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

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User, OHCA

From: Roberts, Karen
Sent: Friday, May 26, 2017 4:37 PM
To: Capone, Claudio
Cc: Cotto, Carmen; Clarke, Ormand; Martone, Kim; Cable, Kimberly (KCable@stfranciscare.org); User, OHCA
Subject: RE: Trinity Health -New England CON filing requirements

Hi Claudio – we have received your request below for additional time to file the required May 31st semi-annual reports for the three Trinity-related transfer of ownership CONs, as follows:

St. Francis – Trinity DN 15-31979-CON
Johnson – Trinity DN 15-32002-CON
St. Mary's –Trinity DN 15-32045-CON

We find it acceptable for the reason that you expressed in your email to Mr. Cotto on May 25th, to provide you with additional time to fulfill this filing for these three docket numbers, but we would appreciate it if the filings are received by end of business day on Wednesday, June 7th.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
Sent: Thursday, May 25, 2017 7:09 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Trinity Health -New England CON filing requirements

Hi Carmen…I spoke to Jennifer and Finance would like to keep the reporting on our current 6 months schedule October 1 – March 31st due May 31 and April-September due November 30. It should be the same for all TH-NE facilities.

That said, can we get a 2 week extension on our May 31st filing?

Thanks,

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 16, 2017 4:26 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio,

This is to follow up on our request below for feedback on our suggested wording to help coordinate the various required filings from Trinity Health-New England.

Last time we spoke you were waiting for Ms. Schneider's return from vacation to provide us with a feedback.

We need to hear from you prior to finalizing the wording in question.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Roberts, Karen
Sent: Friday, February 24, 2017 11:38 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Trinity Health -New England CON filing requirements

Hi Claudio – the wording below is what OHCA staff is thinking will help to better coordinate the various required filings to OHCA from Trinity Health –New England for the three recent transfer of ownership agreed settlements. Before we have this put in an email from our Director, Kim Martone, please take a look and let us know if this will help TH-NE out with having less filing dates to hit for these three CONs. The yellow highlights show where the words "following the Closing Date" appear in the conditions and OHCA's clarifying statement appears then in Red/Bold. Thanks. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

I. Certain Agreed Upon Conditions from Docket Number 15-31979-CON, St. Francis/Trinity - CLOSING/TRANSACTION DATE WAS OCTOBER 1, 2015

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on SFCRHM's website page.
    b. All reports shall remain posted until the third (3rd) anniversary of the Closing Date, except to the extent they are superseded or otherwise rendered inaccurate by subsequent reports and/or information required to be posted pursuant to these Conditions.

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, SFCRHM shall submit to OHCA its Capital Investment Plan detailing the proposed allocation of the $275 million capital investment commitment over the five-year period post-closing. The submitted plans shall account for the full $275M commitment as stated in this proposal and include the following in a format to be agreed upon:

    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
    b. A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and
    c. SFCRHM shall submit written reports updating the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the Hospital's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by SFCRHM's Chief Financial Officer.

14. SFCRHM shall ensure that culturally and linguistically appropriate services are available and integrated throughout its hospital operations, including appropriate interpreter and insurance navigator services for patients, English as a second language training for employees, and cultural competency training for employees. In complying with this Condition, SFCRHM shall be guided by the culturally and linguistically appropriate standards published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, SFCRHM shall submit a written report on its activities directed at meeting this Condition as part of the Annual

Report. The written report shall be posted on SFCRHM Website Page simultaneously with the submission of the Annual Report.

THIRTY DAYS OF THE CLOSING DATE IS NOVEMBER 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON NOVEMBER 30TH ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

II. Certain Agreed Upon Conditions from Docket Number 15-32002-CON, Johnson Memorial/Trinity - CLOSING/TRANSACTION DATE WAS JANUARY 1, 2016

5. Applicants shall submit to OHCA certain information as required by these Conditions on an annual basis (the "Annual Report") up to and including the third (3rd) anniversary of the Closing Date. The Annual Report shall be furnished to OHCA within thirty (30) days of each anniversary of the Closing Date.

    a. All reports and other information required shall be posted on New JMMC's website page.
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    a. A list of planned capital expenditures with detailed descriptions and associated estimated costs; and
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    c. Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from New JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by New JMMC's Chief Financial Officer.

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THIRTY DAYS OF THE CLOSING DATE IS FEBRUARY 1ST. FOR EACH OF THE CONDITIONS NOTED ABOVE (#5,# 9, #14) TRINITY HEALTH – NEW ENGLAND MAY INSTEAD FILE THE MATERIAL ON MAY 31ST ALONG WITH THE FILINGS REQUIRED PURSUANT TO CONDITIONS #10 AND #11.

III. ***Certain Agreed Upon Conditions from Docket Number 15-32045-CON, St. Mary's/Trinity***
- CLOSING/TRANSACTION DATE WAS AUGUST 1, 2016

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL REMAINS DUE AT THIS TIME.

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

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    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
    c. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

180 DAYS OF THE CLOSING DATE IS JANUARY 28, 2017. THIS MATERIAL MAY BE FILED EACH MAY 31ST AND NOVEMBER 30TH AS SET FORTH IN CONDITION #8 AS REFERENCED WITHIN #7.

12. TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

    In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    d. On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

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THIRTY DAYS OF THE CLOSING DATE IS AUGUST 31ST. THIS MATERIAL MAY INSTEAD BE FILED EACH NOVEMBER 30TH ALONG WITH THE MATERIAL DUE PURSUANT TO CONDITIONS #8 AND #9.

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User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Wednesday, June 07, 2017 3:47 PM
To: User, OHCA; Cotto, Carmen; Roberts, Karen
Cc: Schneider, Jennifer; John Rodis; Kyle Jurczyk; Janeanne C. Lubin-Szafranski
Subject: Trinity Health - New England Conditions of CON Filings
Attachments: Saint Francis Trinity Health order requirements Summary of Cost Saving ....pdf; Saint Francis Trinity Health order requirements Summary of Cost Saving draft v1.docx; Johnson Trinity Health New England 5-30 order requirements.pdf; Attachment C Supplemental Stats for JMH.XLSX; Attachment A Detail of 6 month savings 10-1-2016 to 3-31-2017.xlsx; Attachment B JMH report 100-150.xlsx; Saint Mary's Key CON stats Mar 2017.xlsx; Saint Mary's Capital Exp - FA OCHA Info thur MAR17.xlsx; Saint Mary's Report 100_150_300_350_March 2017.xlsx; 15_31979 Attachment C TH-NE Financial Statistics -Mar 17- comp to Sept 16.xlsx; 15_31979 Attachment B2 Cashflow.xls; 15_31979 Attachment B1 TH-NE - CT - SAFNS - Reports 100 150 300 350 3.31.17.xlsx; 15_31979 Attachment A Detail of 6 month savings 3-31-2016.xlsx

Importance: High

Hello,

Attached are Trinity Health – New England's June 7th filings pursuant to our CON Conditions as delineated in Docket Numbers:

- 15-31979-CON, St. Francis/Trinity
- 15-32002-CON, Johnson Memorial/Trinity
- 15-32045-CON, St. Mary's/Trinity

Please feel free to contact me with any questions you may have regarding the attached.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning and Business Development
Trinity Health - New England

claudio.capone@trinityhealth-ne.org
W 860-714-6165
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1000 Asylum Avenue, 4th Floor
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delete it from your computer system. Saint Francis Hospital and Medical Center has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended March 31, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost saving opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Additional interest expense savings for the six months ended March 31, 2017 was approximately $226,000 as a result of favorable interest rates.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This created an overall decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. The benefit related to this change was $650,000 for the six month period ended 3/31/2017. In addition, Saint Francis will realize an additional annual savings in insurance premiums of $1.8 million effective 7/1/2017.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans, Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis recognized an annual benefit in pension expense of $4.2 million for the twelve month period

ended September 30, 2016. For the period from October 1, 2016 to March 31, 2017 the realized benefit was $2.3 million. Furthermore, Trinity and Saint Francis have developed a plan to continue to adequately fund the Saint Francis defined benefit plan consistent with the Trinity Health funding policy. Based on the current obligations under the plan and current funding level, Saint Francis will make contributions of $32.9 million to the plan during the period 7/1/2017-6/30/2018. Historically, Saint Francis was only able to contribute approximately $9 million to the plan annually.

Just prior to Saint Francis joining Trinity Health, a class action lawsuit was brought against Saint Francis relating to the question as to whether Saint Francis' defined benefit plan should be administered as a qualified "church plan" or a plan subject to Employee Retirement Income Security Act (ERISA). Trinity Health system office risk management collaborated with local leadership and was instrumental in resolving this matter. Furthermore, $800,000 of legal fees associated with this matter was paid for by Trinity Health on behalf of Saint Francis.

In January 2017, the employees of Saint Francis were brought onto to Trinity Health benefit programs which provided several enhancements to their benefits. The most significant change is that colleagues working more than twenty hours per week are participating in a defined contribution retirement program which provides a base core contribution of 3% for everyone and a matching contribution for the first 6% of a colleague's contribution. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Saint Francis continues with the transition to the Trinity Health Group Purchasing Organization, HPG. During the period October 1, 2016 to March 31, 2017, this effort has resulted in net supply chain savings of approximately $1.7 million. Most of the current saving was achieved by reducing the cost on existing goods through the implementation of the Trinity Health National Agreements. Other contract savings were realized with various revenue cycle vendors and totaled $219,000 during the same period. Supply Chain integration activity will continue in FY17 and FY18.

Trinity Health – New England, Inc. (TH – NE, formerly known as Saint Francis *Care*, Inc.), on behalf of its member hospitals including Saint Francis Hospital and Medical Center, Johnson Memorial Hospital and Saint Mary's Hospital, is currently working with Trinity Health on ensuring these hospitals continue to deliver high quality care and remain low cost providers within the community. TH-NE and Trinity Health have engaged external consultants to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.0 million benefit to the Connecticut hospitals within TH - NE.

Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings. Saint Francis continues to have a strong census as well as being recognized for its clinical excellence.

See **Attachment D.**

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,300
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$1,664
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$226
H.	Malpractice Insurance Cost	$650
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$219
	Total savings 10/1-3/31	$5,059

Attachment B1

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$14,863,000	($2,419,000)	-14%
2	Short Term Investments	$37,626,000	$22,759,000	($14,867,000)	-40%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$84,118,000	$19,529,000	30%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$36,994,000	($10,492,000)	-22%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$8,913,000	$8,964,000	$51,000	1%
8	Prepaid Expenses	$3,861,000	$2,797,000	($1,064,000)	-28%
9	Other Current Assets	$3,498,000	$3,950,000	$452,000	13%
	Total Current Assets	**$188,768,000**	**$175,120,000**	**($13,648,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$55,311,000	$56,453,000	$1,142,000	2%
2	Board Designated for Capital Acquisition	$42,931,000	$45,721,000	$2,790,000	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$0	($2,118,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$102,174,000**	**$1,814,000**	**2%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,935,000	($2,331,000)	-18%
6	Long Term Investments	$48,717,000	$51,061,000	$2,344,000	5%
7	Other Noncurrent Assets	$7,050,000	$8,864,000	$1,814,000	26%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$428,235,000	$9,424,000	2%
2	Less: Accumulated Depreciation	$43,734,000	$62,758,000	$19,024,000	43%
	Property, Plant and Equipment, Net	**$375,077,000**	**$365,477,000**	**($9,600,000)**	**-3%**
3	Construction in Progress	$14,905,000	$28,823,000	$13,918,000	93%
	Total Net Fixed Assets	**$389,982,000**	**$394,300,000**	**$4,318,000**	**1%**
	Total Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$30,624,000	($3,539,000)	-10%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,397,000	($6,747,000)	-18%
3	Due To Third Party Payers	$8,953,000	$7,509,000	($1,444,000)	-16%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$6,690,000	($235,000)	-3%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$9,764,000	$719,000	8%
	Total Current Liabilities	**$97,230,000**	**$85,984,000**	**($11,246,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$235,217,000	($2,515,000)	-1%
	Total Long Term Debt	**$237,732,000**	**$235,217,000**	**($2,515,000)**	**-1%**
3	Accrued Pension Liability	$227,408,000	$209,405,000	($18,003,000)	-8%
4	Other Long Term Liabilities	$51,868,000	$52,668,000	$800,000	2%
	Total Long Term Liabilities	**$517,008,000**	**$497,290,000**	**($19,718,000)**	**-4%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$70,673,000	$21,451,000	44%
2	Temporarily Restricted Net Assets	$29,372,000	$32,054,000	$2,682,000	9%
3	Permanently Restricted Net Assets	$55,311,000	$56,453,000	$1,142,000	2%
	Total Net Assets	**$133,905,000**	**$159,180,000**	**$25,275,000**	**19%**
	Total Liabilities and Net Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,000	$1,225,669,000	($1,026,535,000)	-46%
2	Less: Allowances	$1,498,710,000	$828,362,000	($670,348,000)	-45%
3	Less: Charity Care	$8,463,000	$9,103,000	$640,000	8%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,000**	**$388,204,000**	**($356,827,000)**	**-48%**
5	Provision for Bad Debts	$14,575,000	$8,642,000	($5,933,000)	-41%
	Net Patient Service Revenue less provision for bad debts	**$730,456,000**	**$379,562,000**	**($350,894,000)**	**-48%**
6	Other Operating Revenue	$38,574,000	$18,266,000	($20,308,000)	-53%
7	Net Assets Released from Restrictions	$3,397,000	$1,993,000	($1,404,000)	-41%
	Total Operating Revenue	**$772,427,000**	**$399,821,000**	**($372,606,000)**	**-48%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$258,412,000	$122,840,000	($135,572,000)	-52%
2	Fringe Benefits	$63,421,000	$27,879,000	($35,542,000)	-56%
3	Physicians Fees	$52,062,000	$22,292,000	($29,770,000)	-57%
4	Supplies and Drugs	$115,390,000	$65,971,000	($49,419,000)	-43%
5	Depreciation and Amortization	$44,179,000	$19,210,000	($24,969,000)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$8,115,000	$4,421,000	($3,694,000)	-46%
8	Malpractice Insurance Cost	$8,753,000	$4,721,000	($4,032,000)	-46%
9	Other Operating Expenses	$211,691,000	$115,900,000	($95,791,000)	-45%
	Total Operating Expenses	**$762,023,000**	**$383,234,000**	**($378,789,000)**	**-50%**
	Income/(Loss) From Operations	**$10,404,000**	**$16,587,000**	**$6,183,000**	**59%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,882,000	$4,945,000	($1,937,000)	-28%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,960,000)	($421,000)	$4,539,000	-92%
	Total Non-Operating Revenue	**$1,922,000**	**$4,524,000**	**$2,602,000**	**135%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Principal Payments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$72,316,000	$49,467,000	($22,849,000)	-32%
2	Short Term Investments	$49,401,000	$30,955,000	($18,446,000)	-37%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$124,168,000	$137,830,000	$13,662,000	11%
4	Current Assets Whose Use is Limited for Current Liabilities	$5,754,000	$0	($5,754,000)	-100%
5	Due From Affiliates	$3,147,000	$6,481,000	$3,334,000	106%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$14,316,000	$15,242,000	$926,000	6%
8	Prepaid Expenses	$8,569,000	$7,391,000	($1,178,000)	-14%
9	Other Current Assets	$13,155,000	$13,435,000	$280,000	2%
	Total Current Assets	**$296,339,000**	**$261,476,000**	**($34,863,000)**	**-12%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$71,841,414	$73,184,000	$1,342,586	2%
2	Board Designated for Capital Acquisition	$67,971,586	$72,277,000	$4,305,414	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$24,717,000	$0	($24,717,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$164,530,000**	**$145,461,000**	**($19,069,000)**	**-12%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$52,748,000	$58,285,000	$5,537,000	10%
7	Other Noncurrent Assets	$18,518,000	$17,556,000	($962,000)	-5%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$551,097,000	$570,246,000	$19,149,000	3%
2	Less: Accumulated Depreciation	$49,168,000	$79,463,000	$30,295,000	$1
	Property, Plant and Equipment, Net	**$501,929,000**	**$490,783,000**	**($11,146,000)**	**-2%**
3	Construction in Progress	$23,674,000	$40,973,000	$17,299,000	73%
	Total Net Fixed Assets	**$525,603,000**	**$531,756,000**	**$6,153,000**	**1%**
	Total Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$68,313,000	$63,707,000	($4,606,000)	-7%
2	Salaries, Wages and Payroll Taxes	$75,613,000	$67,903,000	($7,710,000)	-10%
3	Due To Third Party Payers	$15,903,000	$16,154,000	$251,000	2%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,821,000	$7,479,000	($342,000)	-4%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$11,999,000	$13,487,000	$1,488,000	12%
	Total Current Liabilities	**$179,649,000**	**$168,730,000**	**($10,919,000)**	**-6%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$256,156,000	$253,458,000	($2,698,000)	-1%
	Total Long Term Debt	**$256,156,000**	**$253,458,000**	**($2,698,000)**	**-1%**
3	Accrued Pension Liability	$314,044,000	$288,664,000	($25,380,000)	-8%
4	Other Long Term Liabilities	$79,162,000	$61,880,000	($17,282,000)	-22%
	Total Long Term Liabilities	**$649,362,000**	**$604,002,000**	**($45,360,000)**	**-7%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$123,226,000	$132,238,000	$9,012,000	7%
2	Temporarily Restricted Net Assets	$33,642,000	$36,380,000	$2,738,000	8%
3	Permanently Restricted Net Assets	$71,859,000	$73,184,000	$1,325,000	2%
	Total Net Assets	**$228,727,000**	**$241,802,000**	**$13,075,000**	**6%**
	Total Liabilities and Net Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,903,594,000	$1,990,018,000	($913,576,000)	-31%
2	Less: Allowances	$1,902,814,000	$1,329,832,000	($572,982,000)	-30%
3	Less: Charity Care	$16,893,000	$14,729,000	($2,164,000)	-13%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$983,887,000**	**$645,457,000**	**($338,430,000)**	**-34%**
5	Provision for Bad Debts	$21,382,000	$16,997,000	($4,385,000)	-21%
	Net Patient Service Revenue less provision for bad debts	**$962,505,000**	**$628,460,000**	**($334,045,000)**	**-35%**
6	Other Operating Revenue	$48,990,000	$36,152,000	($12,838,000)	-26%
7	Net Assets Released from Restrictions	$7,991,000	$2,494,000	($5,497,000)	-69%
	Total Operating Revenue	**$1,019,486,000**	**$667,106,000**	**($352,380,000)**	**-35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$447,852,000	$314,233,000	($133,619,000)	-30%
2	Fringe Benefits	$94,930,000	$52,558,000	($42,372,000)	-45%
3	Physicians Fees	$33,406,000	$24,902,000	($8,504,000)	-25%
4	Supplies and Drugs	$162,109,000	$107,533,000	($54,576,000)	-34%
5	Depreciation and Amortization	$50,735,000	$30,251,000	($20,484,000)	-40%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$9,056,000	$5,047,000	($4,009,000)	-44%
8	Malpractice Insurance Cost	$12,300,000	$9,480,000	($2,820,000)	-23%
9	Other Operating Expenses	$212,471,000	$114,986,000	($97,485,000)	-46%
	Total Operating Expenses	**$1,022,859,000**	**$658,990,000**	**($363,869,000)**	**-36%**
	Income/(Loss) From Operations	**($3,373,000)**	**$8,116,000**	**$11,489,000**	**-341%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$5,917,000	$6,960,000	$1,043,000	18%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$54,901,000	($448,000)	($55,349,000)	-101%
	Total Non-Operating Revenue	**$60,818,000**	**$6,512,000**	**($54,306,000)**	**-89%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**
	Other Adjustments:				

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 21,111,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**19,210,000**
Bad debts	**8,642,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,682,000**
Equity transfer	**340,000**
Changes in:	
Accounts receivable--patients, net	**(28,171,000)**
Due from affiliated entities	**10,492,000**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(51,000)**
Prepaid expenses	**1,064,000**
Other assets	**(2,266,000)**
Accounts payable	**(3,539,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(6,747,000)**
Due to third party reimbursement agencies	**(1,444,000)**
Other current liabilities	**719,000**
Accrued pension and retiree health costs	**(18,003,000)**
Other long term liabilities	**800,000**
Net cash provided by operating activities	**10,819,000**
Investing activities:	
Purchases of property, plant and equipment, net	**(23,528,000)**
Decrease in assets whose use is limited	**(1,814,000)**
Decrease in investments	**14,854,000**
Net cash used in investing activities	**(10,488,000)**
Financing activities	
Principal payments on long-term debt	**(2,750,000)**
Net cash used in financing activities	**(2,750,000)**
Net decrease in cash and cash equivalents	**(2,419,000)**
Cash and cash equivalents at beginning of period	**17,282,000**
Cash and cash equivalents at end of period	**14,863,000**

TRINITY HEALTH - NEW ENGLAND, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 14,628,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**30,251,000**
Bad debts	**16,997,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,738,000**
Equity transfer	**(5,433,000)**
Changes in:	
Accounts receivable--patients, net	**(30,659,000)**
Due from affiliated entities	**(3,334,000)**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(926,000)**
Prepaid expenses	**1,178,000**
Other assets	**682,000**
Accounts payable	**(4,606,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,710,000)**
Due to third party reimbursement agencies	**251,000**
Other current liabilities	**1,488,000**
Accrued pension and retiree health costs	**(25,380,000)**
Other long term liabilities	**(17,282,000)**
Net cash used in operating activities	**(21,137,000)**
Investing activities:	
Purchases of property, plant and equipment, net	**(36,404,000)**
Decrease in assets whose use is limited	**24,823,000**
Decrease in investments	**12,909,000**
Net cash provided by investing activities	**1,328,000**
Financing activities	
Principal payments on long-term debt	**(3,040,000)**
Net cash used in financing activities	**(3,040,000)**
Net decrease in cash and cash equivalents	**(22,849,000)**
Cash and cash equivalents at beginning of period	**72,316,000**
Cash and cash equivalents at end of period	**49,467,000**

Saint Francis Hospital and Medical Center

		Mar 17 YTD		Sept 16 YTD		Comments
Monthly Financial Measurement/Indicators						
A.	**Operating Performance:**					
	Operating Margin		4.1%		1.3%	operating income/operating revenues
	Non-Operating Margin		NA		NA	
	Total Margin		10.1%		8.1%	Operating cash flow margin (EBIDA/operating revenue)
	Bad Debt as % of Gross Revenue		0.7%		0.6%	bad debt/total patient serv. Revenue(before allowances)
B.	**Liquidity:**					
	Current Ratio		2.0		1.9	current assets/current liabilites
	Days Cash on Hand		41.7		49.7	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
	Days in Net Accounts Receivables		39.4		33.9	net ar/net patient ser rev(after bd)/days in yr
	Average Payment Period		43.0		44.1	current liabilities/(total exp-depr)/YTD days in yr
C.	**Leverage and Capital Structure:**					
	Long-term Debt to Equity		152.0%		182.7%	total debt/total equity(net assets)
	Long-term Debt to Capitalization		59.6%		64.0%	LTD/LTD+net assets
	Unrestricted Cash to Debt		34.5%		40.0%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
	Times Interest Earned Ratio		4.8		2.3	EBIT/Interest expense
	Debt Service Coverage Ratio		3.6 x		4.2 x	(Net income+int+depr)/(st debt+int exp)
	Equity Financing Ratio		21.4%		17.9%	Net assets/total assets
D.	**Additional Statistics (in thousands)**					
	Income(Loss) from Operations	$	16,587	$	10,404	Net income(loss) from operations
	Revenue Over/(Under) Expense	$	21,111	$	12,326	Net gain(loss)
	EBITDA	$	40,218	$	62,698	based on net income(loss) from operations
	Patient Cash Collected		NA		NA	
	Cash and Cash Equivalents	$	37,622	$	54,908	from cons bs
	Net Working Capital	$	89,136	$	91,538	current assets-current liabilities
	Unrestricted Assets	$	70,673	$	49,222	from cons bs

Source=SAFNS reports 100 150 300 350 331

Trinity Health - New England, Inc (Formerly Saint Francis Care, Inc.)

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	(0.3%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.5%	5.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	1.6	1.6	current assets/current liabilites
Days Cash on Hand	44.2	71.2	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	38.9	46.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.8	67.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	107.9%	115.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	51.2%	52.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	0.6	0.7	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.6	0.6	EBIT/Interest expense
Debt Service Coverage Ratio	3.5 x	3.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	23.8%	21.6%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 8,116	$ (3,373)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 14,628	$ 57,445	Net gain(loss)
EBITDA	$ 43,414	$ 56,418	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 80,422	$ 121,717	from ct0cons hfm
Net Working Capital	$ 92,746	$ 116,690	current assets-current liabilities
Unrestricted Assets	$ 132,238	$ 123,226	from ct0cons hfm

Saint Francis Awards, Accreditations and Recognitions
Fiscal Year 2016 and 2017

Connecticut Joint Replacement Institute ISO 9001:2015 Certified
The Connecticut Joint Replacement Institute at Saint Francis Hospital and Medical Center (CJRI) has been recertified in compliance with the International Standards Organization's (ISO) 9001:2015 standard for health care. First certified in 2014 as an ISO 9001:2008 Quality Management System compliant organization, the Connecticut Joint Replacement Institute (CJRI) remains the only health care facility in Connecticut to be compliant with ISO standards. There are approximately 500 health care providers nationwide with this distinction. The three-year re-certification is awarded by DNV-GL Certification Inc., of Houston, TX, following an intensive audit of CJRI's workflows, quality and safety measurement tools. (Feb. 2017)

2017 Women's Choice Award® as one of America's Best Hospitals for Heart Care
Saint Francis Hospital and Medical Center has been named one of America's Best Hospitals for Heart Care by the Women's Choice Award®, America's trusted referral source for the best in healthcare. The award signifies that Saint Francis Hospital and Medical Center is in the top 9% of 4,789 U.S. hospitals offering heart care services. (Jan. 2017)

2017 Women's Choice Award®, America's Best Hospitals for Bariatric Surgery
Saint Francis Hospital and Medical Center has been named as one of America's Best Hospitals for Bariatric Surgery by the Women's Choice Award®, America's trusted referral source for the best in healthcare. The award signifies that Saint Francis Hospital and Medical Center is in the top 8% of 4,789 U.S. hospitals reviewed. This is the second consecutive year that Saint Francis Hospital and Medical Center has received the Women's Choice Award for Bariatric Surgery. (Jan. 2017)

2017 Women's Choice Award®, America's Best Hospitals for Obstetrics
Saint Francis Hospital and Medical Center has been named as one of America's Best Hospitals for Obstetrics by the Women's Choice Award®, America's trusted referral source for the best in health care. The award signifies Saint Francis Hospital and Medical Center is in the top 17% of 2,815 U.S. hospitals offering obstetrics. (Jan. 2017)

Electronic Medical Record Adoption Model (EMRAM) Stage 7 Award
In recognition of its collaboration among operational, IT resources and partnering vendors to create the best system for delivering care to their patients, Saint Francis Hospital and Medical Center has been awarded with the Electronic Medical Record Adoption Model (EMRAM) Stage 7 Award. Saint Francis collaborated with a specialized niche electronic medical record (EMR) software company and one large vendor to build, test workflow, study, report and exchange data between the two systems. (Nov. 2016)

Transforming Communities Initiative
Saint Francis Hospital and Medical Center, through the Curtis D. Robinson Center for Health Equity, launched the Transforming Communities Initiative that will unite health care systems, community groups and development agencies to address health disparities in Hartford's North End. The Transforming Communities Initiative will bring together Saint Francis, the City of Hartford and Community Solutions to develop programs and strategies aimed at reducing obesity, promoting tobacco-free living, and addressing social determinants that impact current and future health outcomes for the people of the North End of Hartford.

Saint Francis is the second Trinity Health – New England provider to be chosen to be part of a larger Transforming Communities Initiative launched by Trinity Health. The first six participants announced in April included Mercy Medical Center. Over the next five years, Trinity Health will invest approximately $80 million in grants, loans, community match dollars and services in those communities.

"A" Rating for the Leapfrog Group
Saint Francis Hospital and Medical Center is one of only six hospitals in the state designated with an "A" safety score rating by the Leapfrog Group. This is the 8th "A" rating since 2012, something no other hospital has attained. The Hospital Safety Score℠ grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. The grades are derived from analysis of publicly available data using evidence-based, national measures of hospital safety. Leapfrog assigned scores to more than 2,500 hospitals nationwide, including 27 hospitals in Connecticut.

Becker's Hospital Review - "100 Hospitals with Great Orthopedic Programs"
Saint Francis Hospital and Medical Center has been named to Becker's Hospital Review 2016 list recognizing it as one of the "100 Hospitals with Great Orthopedic Programs" in the United States. Saint Francis is the only Connecticut hospital on the list and appears for the third consecutive year.

Women's Choice Award
Saint Francis Hospital and Medical Center has received the 2016 Women's Choice Award® as one of America's Best Breast Centers. This evidence-based designation is the only award that identifies the country's best breast centers based on robust criteria that considers female patient satisfaction and clinical excellence. The list of over 374 award winners, including the Maximilian E. and Marion O. Hoffman Foundation Breast Health Center at Saint Francis, represents breast centers that have met the high standards of the National Accreditation Program for Breast Centers (NAPBC) and carry the Breast Imaging Center of Excellence (BICOE) seal from the American College of Radiology. They have also scored above the national average on the Centers for Medicare and Medicaid Services patient recommendation measures, or their equivalent.

Johnson Memorial Hospital

		Mar 17 YTD		Sept16* YTD	Comments
Monthly Financial Measurement/Indicators					
A. Operating Performance:					
Operating Margin		1.2%		-7.0%	operating income/operating revenues
Non-Operating Margin		NA		NA	
Total Margin		6.4%		-0.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue		1.3%		1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:					
Current Ratio		0.8		0.8	current assets/current liabilites
Days Cash on Hand		15.5		9.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables		76.9		109.4	net ar/net patient ser rev/days in yr
Average Payment Period		164.0		186.9	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:					
Long-term Debt to Equity		823.7%		-402.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization		89.0%		133.8%	LTD/LTD+net assets
Unrestricted Cash to Debt		8.1%		7.5%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio		2.0		(4.5)	EBIT/Interest expense
Debt Service Coverage Ratio		2.59 x		-0.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio		6.1%		-11.3%	Net assets/total assets
D. Additional Statistics (in thousands)					
Income(Loss) from Operations*	$	399	$	(3,214)	Net income(loss) from operations
Revenue Over/(Under) Expense	$	350	$	(3,474)	Net gain(loss)
EBIDA	$	2,107	$	(247)	based on net income(loss) from operations
Patient Cash Collected		NA		NA	
Cash and Cash Equivalents	$	1,766	$	1,696	from bs
Net Working Capital	$	(2,835)	$	(7,177)	current assets-current liabilities
Unrestricted Assets	$	2,084	$	(6,169)	from bs

*reflects 01/16-09/30/16

	Saint Mary's Health System (Consolidated)	Month		Year to Date	
		Mar 2017	Prior Year	Mar 2017	Prior Year
A.	**Operating Performance**				
	Operating Margin	7.3%	6.6%	2.4%	2.4%
	Non-Operating Margin	1.3%	-0.2%	0.3%	0.3%
	Total Margin	8.6%	6.4%	2.8%	2.7%
	Bad Debt as % of Gross Revenue	0.1%	1.3%	1.0%	1.3%
B.	**Liquidity**				
	Current Ratio	1.89	2.13	1.89	2.13
	Days Cash on Hand	26	24	26	24
	Days in Net Accounts Receivable	38	41	38	41
	Average Payment Period	50	55	50	55
C.	**Leverage and Capital Structure**				
	Long-term Debt to Equity	0.01	0.24	0.01	0.24
	Long-term Debt to Capitalization	0.01	0.20	0.01	0.20
	Unrestricted Cash to Debt	28.23	1.44	28.23	1.44
	Times Interest Earned Ratio	595.9	86.4	209.20	33.87
	Debt Service Coverage Ratio	14.0	11.5	8.38	6.64
	Equity Financing Ratio	2.63	3.85	2.63	3.85
D.	**Additional Statistics (in thousands)**				
	Income from Operations	$ 2,044	$ 1,854	$ 3,871	$ 3,725
	Revenue Over/(Under) Expense	$ 2,398	$ 1,807	$ 4,411	$ 4,199
	EBITDA	$ 3,512	$ 2,872	$ 12,568	$ 9,959
	Patient Cash Collected	$ 27,894	$ 28,833	$ 149,302	$ 148,473
	Cash and Cash Equivalents	$ 20,937	$ 19,016	$ 20,937	$ 19,016
	Net Working Capital	$ 23,409	$ 25,933	$ 23,409	$ 2,533
	Unrestricted Assets	$ 60,607	$ 36,777	$ 606,607	$ 36,777
	Credit Ratings (S&P, FITCH and Moody's)				

Source=SAFNS reports 100 150 300 350 3311

Trinity Health - New England, Inc (Formerly Saint Francis Care, Inc.)

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	(0.3%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.5%	5.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.9%	0.7%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	1.6	1.6	current assets/current liabilites
Days Cash on Hand	44.2	71.2	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	38.9	46.1	net ar/net patient ser rev/days in yr
Average Payment Period	48.8	67.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	107.9%	115.4%	total debt/total equity(net assets)
Long-term Debt to Capitalization	51.2%	52.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	0.6	0.7	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.6	0.6	EBIT/Interest expense
Debt Service Coverage Ratio	3.5 x	3.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	23.8%	21.6%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 8,116	$ (3,373)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 14,628	$ 57,445	Net gain(loss)
EBITDA	$ 43,414	$ 56,418	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
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Net Working Capital	$ 92,746	$ 116,690	current assets-current liabilities
Unrestricted Assets	$ 132,238	$ 123,226	from ct0cons hfm

Saint Francis Hospital and Medical Center

	Mar 17 YTD	Sept 16 YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	4.1%	1.3%	operating income/operating revenues
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Times Interest Earned Ratio	4.8	2.3	EBIT/Interest expense
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Equity Financing Ratio	21.4%	17.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 16,587	$ 10,404	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 21,111	$ 12,326	Net gain(loss)
EBITDA	$ 40,218	$ 62,698	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 37,622	$ 54,908	from cons bs
Net Working Capital	$ 89,136	$ 91,538	current assets-current liabilities
Unrestricted Assets	$ 70,673	$ 49,222	from cons bs

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$1,675
B.	Fringe Benefits (workers comp)	$335
C.	Contractual Labor Fees	($1,204)
D.	Medical Supplies and Pharmaceutical Cost	$75
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$30
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$114
K.	Other Operating Expense	$373
	Total savings 10/1/2016-3/31/2017	$1,398

DESCRIPTION	DEPT	QUAN	CLASS	TYPE	ACQ DATE	ENTRY PER
FABIUSTIRO ANESTHESIA MACHINES	7220	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
INTELLIVUE MONITORS & ACCESSORIES	7220	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
STERILIZATION CONTAINER	7570	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
ISTAT 1 WIRELESS ANALYZER	7361	3	MOVEABLE	MEDICAL	8/31/2016	11/2016
SCOPES 0 DEG & 30 DEG CURETTATE	7850	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
VC- 10 VACUUM	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
BLADDER SCAN BVI 9400	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
LIPOSCULTPTOR & ACCESSORIES	7850	1	MOVEABLE	MEDICAL	8/31/2016	11/2016
SUTURE RETRIEVER ACCESSORIES	7850	40	MOVEABLE	MEDICAL	8/31/2016	11/2016
SCOPE HOPKINS 11 30 DEG	7850	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
B3000 BLACK BADGE & BATTERIES	7010	40	MOVEABLE	MEDICAL	8/31/2016	11/2016
CO2 MONITOR & ACCESSORIES	7540	4	MOVEABLE	MEDICAL	8/31/2016	11/2016
ARTIC SUN 5000E TEMP	6500	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
OPTIPLEX 7040 PC & MONITORS	9080	10	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
BUILDING SIGN	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
CONDENSING UNIT	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
HVAC CLEANING & SANTIZING	7850	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
FIRE & SMOKE DAMPER	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
FLOOR SCRUBBERS SINGLE & DUAL	8100	2	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
DEHUMIDIFIER TRAGER BASEMENT	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
EXPANSION VALVE TRAGER	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
WALL COVERING - AUDITORIUM	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
COOLONG COL REPLACEMENT	8300	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
CATH LAB # 2 RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
SLEEP LAB RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
BOARDROOM RENOVATION	9000	1	BLDG IMPR	NONMEDICAL	8/31/2016	11/2016
10 FT HOSES	7540	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
REVERSE OSMOSIS SYSTEM	7010	1	MOVEABLE	NONMEDICAL	8/31/2016	11/2016
HARMONYAIR LIGHT SYSTEM	7070	1	FIXED	NONMEDICAL	8/31/2016	11/2016
RECUMBENT CROSS TRAINER	7420	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CONTAINERS FOR STERILIZATION	7570	75	MOVEABLE	MEDICAL	9/30/2016	12/2016
TITANIUM GE MRI TOOL KIT	8320	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
LIPOTOWER ASPIRATOR / INFIL	7850	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CART, SINGLE TIER CORNER	7280	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CAMERA, CODER & STORAGE	8350	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
VOLUSON P8	7070	1	MOVEABLE	MEDICAL	9/30/2016	12/2016
CARBON FIBER BOARD	7460	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
CHESHIRE UC INSTALL	7700	1	FIXED	NONMEDICAL	9/30/2016	12/2016
DELL OPTOPLEX 7040	9080	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
MARKETING FURNITURE	9190	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016

NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
COUNTER FOR PSYCHIATRIC WARD	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
FEASABILITY STUDY OPEN OFFICE	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
COUNTER TOPS THROUGHOUT HOSPITAL	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
AUDITORIUM RENOVATION	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
FIRE STOP	8300	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
MAIN MEGAWATT METER REPLACEMENT	8300	1	FIXED	NONMEDICAL	9/30/2016	12/2016
EPOXY COATED SHOWER BASE	8300	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
BLASIUS 2014 CHEVROLET CRUZE	7361	1	AUTO	NONMEDICAL	9/30/2016	12/2016
SLEEP LAB BUDGETED CONTRACT	7980	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
MEP	7980	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
RODI PIPING & INSTALL	7010	1	FIXED	NONMEDICAL	9/30/2016	12/2016
SEER 1000	7901	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
MAMMOTEST	7280	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
EMERGENCY TEMP WALL	8300	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
FURNISH & INSTALL CARPET & TILE	7850	1	FIXED	NONMEDICAL	10/31/2016	01/2017
DAYCARE REMEDIATION	8460	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
BRIO BEDSIDE CABINETS & OVERHEAD ART	7180	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
AAON RTU GAS METERING	8300	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
SYNGO DYNAMICS SYSTEM	9080	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
REMOVE OLD HTP/ PUT NEW IN ITS PLACE	8300	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
BRAINLAB OPTICAL	7010	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
V500 WORKSTATIONS	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
SMART CARE MONITORING	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
AQUILLION PRIME 80	7280	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
MOB 4TH FLOOR LOBBY	8300	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
FLEX-X UTRETERSCOPE	7010	1	MOVEABLE	MEDICAL	10/31/2016	01/2017
SLEEP DESIGN MOB	7980	1	BLDG IMP	NONMEDICAL	10/31/2016	01/2017
CDIS MULTIGROUPING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
LICENSE/ SUPPORT/ TRAINING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
CARBON FIBER BOARD	7460	1	MOVEABLE	NONMEDICAL	9/30/2016	12/2016
TRANSDUCER CONVEX & LINEAR	7461	2	MOVEABLE	MEDICAL	11/30/2016	02/2017
OR ROOM REPAIRS	7010	1	FIXED	NONMEDICAL	11/30/2016	02/2017
DEHUMIDIFIER INSTALL - TRAGER	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
VIDEO INTERCOM	7980	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
SOFTWARE LICENSE FEES	8400	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
DOOR ACCESS SYSTEM	8460	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
HARMONY LIGHTS/ FP	7850	7	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
CABLING	7980	1	FIXED	NONMEDICAL	10/31/2016	01/2017
CABINET & SHELVES	8300	8	FIXED	NONMEDICAL	11/30/2016	02/2017
FRAME NEW WALL	8300	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CABINETS	7850	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CIRCUIT FOR INBND/OUTBND SWITCHING	8300	1	FIXED	NONMEDICAL	11/30/2016	02/2017
DISPOSABLE LINERS	8100	24	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
PCKGO HEAT EXCHGE/PUMP REPLACEMENT	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
SLEEP LAB PROJECT	7980	1	FIXED	NONMEDICAL	11/30/2016	02/2017

SLEEP LAB PROJECT	7980	1	FIXED	NONMEDICAL	11/30/2016	02/2017
CARPET CHILD DEV	8460	1	FIXED	NONMEDICAL	11/30/2016	02/2017
INTUITIVE ROBOT BUYOUT	7010	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
EV100 CLINICAL PLTFM & SERVICE	7220	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
EV100 CLINICAL PLTFM & SERVICE	6510	1	MOVEABLE	MEDICAL	11/30/2016	02/2017
FURNISH & INSTALL CARPET & TILE	7850	1	FIXED	NONMEDICAL	11/30/2016	02/2017
FURNITURE	9170	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
DOUBLE CATCH BASIN	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- BLOCK WINDOWS IN LAWLOR	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- CONSTRUCTION PROCESS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- FLOORING VINYL	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- DUCTWORK & EXHAUST FANS INSTAL	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- ELECTRICAL CONTROLS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- PAINTING STAIRWELLS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- SECURITY WORK SPACE	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
911 PJT- STRIPPING AND WAXING FLOORS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT- INTERIOR SIGNS	8300	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
911 PJT-ACCESS CONTROL SYSTEM	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
911 PJT-SPRINKLER HEADS	8300	1	BLDG IMP	NONMEDICAL	11/30/2016	02/2017
INTERIOR SIGN BRAILLE	7980	1	MOVEABLE	NONMEDICAL	11/30/2016	02/2017
V500 WORKSTATIONS	7540	4	MOVEABLE	MEDICAL	10/31/2016	01/2017
1320 WEST MAIN ADDITION	8300	1	BLD IMP	NONMEDICAL	12/31/2016	03/2017
BOLLAND AT OXYGEN TANKS REMOVE & INSTA	8300	1	LAND IMP	NONMEDICAL	12/31/2016	03/2017
4 FT POS PRESS RECIRC COMP	7120	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
HARMONY DUAL & SINGLE LIGHTING	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
DR TRAGER NEW FLOOR & FURNITURE	9831	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
ULTRASOUND SPARQ	7290	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ATRION TELEPHONE SYSTEM	9100	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
LIFE POLE W/LIFT & ASSIST	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
BRAVO RECEIVER/SOFTWARE/RECORDER	7850	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
PROFESSIONAL DESIGN	8300	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
TITAN 450 WATT ZENON LIGHT	7010	3	MOVEABLE	MEDICAL	12/31/2016	03/2017
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
CDIS TRAINNG/LICENSE	8400	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
ATOMLAB 500 DOSE CALIB	7630	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ULTRAFIN LITHO STIRUP PAIR	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
IS4000 DA VINCI XI	7010	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
STERRAD 100NX ™	7570	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
SEER 1000	7901	6	MOVEABLE	MEDICAL	12/31/2016	03/2017
WEST MAIN TRANSFORMER RELOCATION	8300	1	FIXED	NONMEDICAL	12/31/2016	03/2017
ROBOTIC CARRIER FOR NIGARA	7570	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
FLOORING	7010	1	FIXED	NONMEDICAL	12/31/2016	03/2017
BASE BID	8300	1	FIXED	NONMEDICAL	12/31/2016	03/2017
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL	12/31/2016	03/2017
PROFUSION UPGRADE	9080	1	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
CADAVER LIFT CONVEYOR	7361	1	MOVEABLE	MEDICAL	12/31/2016	03/2017
ENTERAL SYRINGE PUMP	6750	3	MOVEABLE	MEDICAL	12/31/2017	03/2018

C0MPELLENT SC220 ENCLOSURE	9080	3	MOVEABLE	NONMEDICAL	12/31/2016	03/2017
POWER LED 175 LIGHT SOURCE	7010	2	MOVEABLE	MEDICAL	12/31/2017	03/2018
NVSC PAINTING (WATER DAMAGE)	7850	1	BLDG IMPR	NONMEDICAL	9/30/2016	12/2016
HP DL380 G9 8GB RAM	7280	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
LICENSE/ SOFTWARE/ SUPPORT	7010	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
POWEREDGE R730 SERVER	9080	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SHELVING	7180	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
COMPELLENT SC220 ENCLOSURE	9080	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
same						
same						
same						
WEST MAIN ADDITION	8300	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
TRUSYSTEM 7000DV & ROBOTIC PKG	7010	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MOB SLEEP LAB RENOVATION	7980	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
PARKING GARAGE ASSESSMENT CONDITION	8300	1	BLDG IMP	NONMEDICAL	1/31/2017	04/2017
LIGHTING UPGRADE	8300	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SUNQUEST PJT/ TV, DESK,ACCESS	7361	3	MOVEABLE	MEDICAL	1/31/2017	04/2017
same						
OR LIGHT SUPPORT SYSTEM	7070	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
SHIMADZU PORTABLE X-RAY	7280	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
WALLS IN SLEEP LAB	7980	1	FIXED	NONMEDICAL	1/31/2017	04/2017
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
WARMING CABINET #5524	7340	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MOB 4TH FL LOBBY NEW WALL & DOOR	8300	1	FIXED	NONMEDICAL	1/31/2017	04/2017
FIRE ALARM PANEL	8300	1	MOVEABLE	NONMEDICAL	1/31/2017	04/2017
O'BRIEN PLUMBING	8300	1	FIXED	NONMEDICAL	1/31/2017	04/2017
PACEMAKER EXTERNAL	6510	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
AQUILION CT SCAN PYMT	7280	1	MOVEABLE	MEDICAL	1/31/2017	04/2017
MONITORS, CAMERAS, LIGHT PKG	7010		MOVEABLE	MEDICAL	42094	6/2015
LICENSE/ SUPPORT/ TRAINING	8400	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
TABLE MOTION UPGRADE	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
FLOORING	7010	1	FIXED	NONMEDICAL	2/28/2017	05/2017
FLOORING	8300	1	FIXED	NONMEDICAL	2/28/2017	05/2017
GAS CHARBOILER INSTALL	8000	1	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
SERVERS	9080	4	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
PROFESSIONAL SERVICES WMUC	7903	1	BLDG IMP	NONMEDICAL	2/28/2017	05/2017
FIBROSCAN 502 TOUCH	7850	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
ACUSON SC2000 MAINFRAME	7220	1	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
CHAIRS, ALL STEEL TASK	7070	15	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
SPECTRUM IV PUMPS	7800	50	MOVEABLE	MEDICAL	2/28/2017	05/2017
same						
ADDITIONAL CAMERAS	8350	9	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
same						
SHELVING & CABINETS	7909	2	MOVEABLE	NONMEDICAL	2/28/2017	05/2017

BASE CABINET & COUNTERTOPS	7070	2	MOVEABLE	NONMEDICAL	2/28/2017	05/2017
URETERSCOPE FLEXIBLE	7010	1	MOVEABLE	MEDICAL	2/28/2017	05/2017
SYNGO DYNAMICS SYSTEM	9080	1	MOVABLE	NONMEDICAL	10/31/2016	01/2017
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL	12/31/2016	03/2017
SOFTWARE SERVICES	7280	2	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
INFUSION ANALYZER	8320	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
APPLICATION & CERTIFICATE	7980	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
ARCHITECTUAL/MEP	7980	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
ARCHITECTUAL/MEP	7980		BLDG IMP	NONMEDICAL	3/31/2017	06/2017
TRIAGE PROJECT	8300	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
					3/31/2017	06/2017
PF6001 MAIN UNIT	7550	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
FLOORING/INSTALL	7570	1	FIXED	NONMEDICAL	3/31/2017	06/2017
MARTINS ARM RETRACTOR	7010	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
ESPRESSO MACHINE	8000	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
UPGRADE VIRTUAL SIS SERVER	9080	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
SPECTRUM IV PUMPS	7800	30	MOVEABLE	MEDICAL	3/31/2017	06/2017
PIPE TESTING PJT 911	8300	1	BLDG IMP	NONMEDICAL	3/31/2017	06/2017
MONITOR DEMOSURE SIGNVS4	6150	2	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
MONITOR DEMOSURE SIGNVS4	6130	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
DEPT OF MEDICINE DOOR	8300	1	FIXED	NONMEDICAL	3/31/2017	06/2017
FLEX-X URETERSCOPE	7010	1	MOVEABLE	MEDICAL	3/31/2017	06/2017
INTELLIVUE MULTI SERVER	6500	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
PRINTER CONNEX 3D	8320	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
ASTER TEE (WATER & AIR) SYSTEM	7440	1	MOVEABLE	NONMEDICAL	3/31/2017	06/2017
PROFESSIONAL SERVICES WMUC	7903	1	BLDG IMP	NONMEDICAL	2/28/2017	05/2017

LOCATION	AMT	VENDOR	PO	SCHEDULE 1	METHOD	EST MO.	
ANES	59,992.08	DRAEGER MED	1614690			60	Aug-16
ANES	50,254.20	PHILIPS 19413	1615589			60	Aug-16
NVSC	13,894.57	AESCULAP	1618025			84	Aug-16
LAB	28,060.47	ABBOTT LAB	1617180			60	Aug-16
NVSC	9,618.00	KARL STORZ	1616167			84	Aug-16
NVSC	5,205.50	OLYMPUS 17199	1616166			84	Aug-16
NVSC	18,316.00	VERATHON	1616110			84	Aug-16
NVSC	19,376.45	MICROAIRE	1616161			84	Aug-16
NVSC	38,916.00	ARTHREX	1616174			84	Aug-16
NVSC	9,300.40	KARL STORZ	1616164			84	Aug-16
OR	20,552.00	VOCERA	1616606			84	Aug-16
RESP	5,453.04	DRAEGER MED	1614719			120	Aug-16
CCU	50,494.00	BARD MED	1616616			84	Aug-16
IT	27,050.40	DELL - 18065	1616179			60	Aug-16
NVSC	2,200.00	CONNECTICUT SIGN	1615432			120	Aug-16
NVSC	23,316.00	SARRACCO	1614100			120	Aug-16
NVSC	23,203.50	STEAMATIC OF CT	1616595			60	Aug-16
PLANT	3,650.00	BRAND	1611712			120	Aug-16
PLANT	14,248.40	GRAINGER	1616342			60	Aug-16
PLANT	2,647.50	GOODHILL	1616795			60	Aug-16
PLANT	2,618.00	GOODHILL	1616840			60	Aug-16
PLANT	10,530.30	H2Z DESIGN	1615047			60	Aug-16
PLANT	45,350.00	MACRI	1609255			120	Aug-16
PLANT	70,203.36	O & G IND	1617840			120	Aug-16
PLANT	24,400.75	O & G IND	1617844			120	Aug-16
PLANT	18,518.50	ALL-PHASE	1512213			120	Aug-16
PRESP	647.44	DRAEGER MED	1614693			60	Aug-16
SURGERY	16,500.00	AMERICAN AQUA	1614998			84	Aug-16
WIC	49,805.83	STERIS	1616347			120	Aug-16
CARD REH	4,189.00	NUSTEP	1619582			84	Sep-16
CENTRAL STI	5,130.40	AESCULAP	1618052			84	Sep-16
CLINICAL	3,775.95	IMPREX INTERNATIONAL	1618781			84	Sep-16
NVSC	6,922.35	MICROAIRE	1616161			120	Sep-16
OR	295.92	STERIS	1618734			60	Sep-16
RAD	10,865.17	AFC IND	1616283			120	Sep-16
SECURITY	5,500.00	STERLING SECURITY	1617528			60	Sep-16
WIC	8,480.00	GE HEALTHCARE	1615162			84	Sep-16
CATH LAB	2,250.00	TZ MEDICAL	1600810			84	Sep-16
CHESHIRE U(	8,485.00	STERLING SECURITY	1615061			60	Sep-16
IT	14,596.44	DELL MARKETING	1619402			60	Sep-16
MARKETING	7,144.73	WB MASON	1615438			120	Sep-16
NVSC	5,020.00	D AND D PAINTING	1615061			60	Sep-16

NVSC	28,024.00	D AND D PAINTING	1614102	60	Sep-16
PLANT	2,527.20	DISPLAY WRIGHT	1618457	180	Sep-16
PLANT	2,545.00	H2Z DESIGN	1618458	36	Sep-16
PLANT	15,880.90	DISPLAY WRIGHT	1618662	180	Sep-16
PLANT	18,662.55	H2Z DESIGN	1618858	60	Sep-16
PLANT	9,818.00	BRAND SERVICES	1611773	120	Sep-16
PLANT	2,750.00	MCPHEE	1618701	120	Sep-16
PLANT	10,455.00	THE S CARPENTER	1618624	120	Sep-16
SECURITY	12,805.60	BLASIUS	NA	60	Sep-16
SLEEP	49,863.27	O & G IND	1618810	36	Sep-16
SLEEP	1,400.00	MOSER	1619208	36	Sep-16
SURGERY	13,500.00	HARRY GRODSKY & CO	1615004	120	Sep-16
CARD	1,362.24	GE HEALTHCARE	1616173	84	Oct-16
RAD	121,500.00	MAMMOTONE	1615447	60	Oct-16
PLANT	3,057.97	THE S CARPENTER	1620226	60	Oct-16
NVSC	9,575.00	M FRANK HIGGINS	1620228	60	Oct-16
DAYCARE	4,689.00	COMMUNITY PLAYTHING	1620270	60	Oct-16
PLANT	19,699.20	HILL ROM 17746	1616344	180	Oct-16
PLANT	3,500.00	SIEMENS 3898	1605035	60	Oct-16
IT	67,061.70	SIEMENS 3898	1612127	60	Oct-16
PLANT	2,031.00	INDUSTRIAL RIGGERS	1700378	60	Oct-16
OR	105,000.00	OLYMPUS 16331	1700259	84	Oct-16
RESP	95,513.30	DRAEGER	1614693	60	Oct-16
RESP	26,079.32	DRAEGER	1614719	60	Oct-16
DIAG	265,401.30	TOSHIBA	15209.17	84	Oct-16
PLANT	4,200.00	CLASSIC BLDRS	1700836	120	Oct-16
OR	19,989.90	KARL STORZ	1701017	84	Oct-16
SLEEP	19,940.00	MOSER PILON	NA	120	Oct-16
HEALTH INFC	6,000.00	3M HEALTH	1616620	60	Oct-16
HEALTH INFC	51,927.10	3M HEALTH	1616705	60	Oct-16
CATH LAB	(180.00)	TZ MEDICAL	1600810	84	Oct-16
IR	14,250.00	HITACHI ALOKA	1700321	60	Nov-16
OR	38,156.25	WB MASON	1608995-BL	120	Nov-16
PLANT	2,647.50	GOOD HILL	1616795	84	Nov-16
SLEEP	2,350.00	STERLING SEC	1617656	60	Nov-16
HEALTH INFC	11,645.16	3M HEALTH	1616705	60	Nov-16
CHILD DEV	4,400.00	STERLING SEC	1617874	120	Nov-16
NVSC	9,383.41	STERIS 16811	1613193	180	Nov-16
NVSC	815.00	COMNET CONN	1617660	240	Nov-16
PLANT	2,550.00	DISPLAY WRIGHT	1701804	180	Nov-16
PLANT	5,080.00	DISPLAY WRIGHT	1701803	120	Nov-16
NVSC	9,093.50	DISPLAY WRIGHT	1614233	180	Nov-16
PLANT	13,180.00	ELECTRICAL WHOLESALES	1700192	240	Nov-16
ENVIRON	182.40	HILL ROM	1616344	24	Nov-16
PLANT	75,031.00	MACRI ASSOCIATES	1613188	120	Nov-16
SLEEP	25,118.76	O AND G	1702057	120	Nov-16

SLEEP	78,461.40	O AND G	1702014	120	Nov-16
CHILD DEV	11,532.38	CORPORATE DESIGN	1701974	60	Nov-16
SURERY	310,500.00	DELAGE LANDEN FINANCIA	NA	84	Nov-16
ANES	52,570.00	EDWARDS LIFE	1701214	84	Nov-16
CVU	52,570.00	EDWARDS LIFE	1701215	84	Nov-16
NVSC	4,766.00	M FRANK HIGGINS	1620228	60	Nov-16
QUAL MNGMT	2,895.21	WB MASON	1619347	120	Nov-16
PLANT	10,750.00	LOUREIRO CONTRACTORS	1619902	300	Nov-16
PLANT	1,494.00	NAUGATUCK WINDOW & GI	1606756	120	Nov-16
PLANT	280,237.70	S CARPENTER	VARIOUS	120	Nov-16
PLANT	1,069.96	CORPORATE DESIGN	1608144	120	Nov-16
PLANT	5,028.00	GOOD HILL	1610915	120	Nov-16
PLANT	23,803.46	VULCAN SECURITY	1610516	120	Nov-16
PLANT	8,185.00	D AND D PAINTING	1608155	120	Nov-16
PLANT	10,500.00	RED THREAD	1604378	120	Nov-16
PLANT	1,932.82	PREFERRED BUILDING MAI	NA	120	Nov-16
PLANT	900.00	CONNECTICUT SIGNCRAFT	NA	60	Nov-16
PLANT	6,350.00	TPC ASSOCIATES	1609806	120	Nov-16
PLANT	6,475.00	MACK FIRE	1612267	120	Nov-16
SLEEP	1,400.00	CONNECTICUT SIGNCRAFT	NA	60	Nov-16
RESP	(1,324.81)	DRAEGER	1614693	60	Nov-16
PLANT	7,333.62	CHIANIS & ANDERSON	1703283	180	Dec-16
PLANT	4,450.00	COCCHIOLA PAYING	1620008	180	Dec-16
PHARMACY	16,028.00	NUAIRE	1616345	84	Dec-16
OR	965.00	STERIS	1502633	180	Dec-16
TRAGER	26,143.50	WB MASON	1616821	60	Dec-16
ULTRASOUNI	56,658.23	PHILIPS HEALTH	1703124	60	Dec-16
COMM	567,760.45	ATRION PROJECT	VARIOUS	120	Dec-16
OR	8,899.16	ALIMED	1703472	60	Dec-16
NVSC	6,495.00	COVIDEN	1703750	60	Dec-16
PLANT	9,100.00	MILONE	1620105	120	Dec-16
OR	26,040.00	CARDIO MED	1703743	84	Dec-16
OR	295.92	STERIS	1703058	84	Dec-16
HIS	11,645.16	3M HEALTH 18731	1616705	60	Dec-16
NUCLEAR	5,850.00	PINESTAR	1703759	84	Dec-16
OR	7,370.28	ALIMED	1703469	84	Dec-16
OR	1,860,000.00	INTUITIVE SURGICAL	1704039	84	Dec-16
CENTRAL STI	110,000.00	ADVANCED STERILIZATION	1703849	84	Dec-16
CARDIOLOGY	5,448.96	GE MEDICAL	1616173	84	Dec-16
PLANT	15,588.14	PARK WEST	1704063	120	Dec-16
CENTRAL STI	7,287.00	MEDISAFE	1703738	84	Dec-16
OR	10,750.00	WB MASON	1608995-BL	120	Dec-16
PLANT	10,688.17	O AND G	1704238	120	Dec-16
CENTRAL STI	26,580.10	CARDINAL HEALTH	1704227	120	Dec-16
IT	70,496.00	COMPUMEDICS	1703948	60	Dec-16
BIOMEDICAL	21,945.00	RYAN MEDICAL	1619073	120	Dec-16
NICU	7,125.00	MEDELA	1704567	84	Dec-16

IT	7,411.52	DELL MRKTG 18065	1704225			60	Dec-16
OR	13,990.00	KARL STORZ	1704414			120	Dec-16
NVSC	(24,287.46)	D AND D PAINTING	1614102			60	Dec-16
RAD	10,994.91	MERGE	1704457			60	Jan-17
	(479.91)	MERGE	1704457			60	Jan-17
OR	46,542.00	VOCERA	1703737			60	Jan-17
IT	38,052.03	DELL - 18065	1704231			60	Jan-17
INVENTORY	1,123.49	INTERMETRO	1703952			240	Jan-17
	112.06	INTERMETRO	1703952			240	Jan-17
IT	80.16	DELL - 18065	1704225			60	Jan-17
	2,778.16	DELL - 18065	1704225			60	Jan-17
	57,993.94	DELL - 18065	1704225			60	Jan-17
	28,841.24	DELL - 18065	1704225			60	Jan-17
PLANT	12,109.81	CHAINIS	1704879			240	Jan-17
OR	92,620.00	TRUMPF	1704988			84	Jan-17
SLEEP	1,455.00	MOSER PILON	1705376			240	Jan-17
PLANT	14,350.00	WALKER RESTORATION	1700043			240	Jan-17
PLANT	63,329.38	ENVIRONMENTAL SERVICE	1702731			120	Jan-17
LAB	2,414.88	CDW	1705569			84	Jan-17
	2,936.13	CDW	1705569			84	Jan-17
WIC	12,875.00	CHALLENGE ENG	1616364			180	Jan-17
RAD	44,900.00	MEDICAL IMAGING	1704180			120	Jan-17
PLANT	4,043.49	O AND G IND	1703278			120	Jan-17
FOOD	3,186.69	PERFORMANCE INT	1705599			120	Jan-17
MRI	6,262.80	GETINGE	1705520			120	Jan-17
PLANT	4,200.00	CLASSIC BLDRS	1700836			240	Jan-17
PLANT	10,807.00	SIMPLEX	1705425			120	Jan-17
PLANT	13,063.00	THE S CARPENTER	1703623			300	Jan-17
CVICU	5,800.00	MEDTRONIC 17359	1706312			60	Jan-17
RAD	265,401.30	TOSHIBA	1520917			60	Jan-17
OR	(19,166.00)	STERIS CORP - 16811	1502633	SCHEDULE 1	STRAIGHT	60	Jan-17
HEALTH INFC	(36,162.58)	3M HEALTH	1616705	SCHEDULE 1	STRAIGHT	60	Jan-17
OR	50,000.00	INTUITIVE SURGICAL	1704039			84	Feb-17
OR	7,333.15	WB MASON	1705901-BL			120	Feb-17
PLANT	6,565.60	WB MASON	1608995-BL			120	Feb-17
FOOD	7,838.00	PERFORMANCE INT	1705599			120	Feb-17
IT	81,007.00	SIEMENS - 20981	1615801			60	Feb-17
WMUC	12,780.33	CHIANIS & ANDERSON	12780.33			240	Feb-17
NVSC	85,000.00	ECHOSENS	1704624			84	Feb-17
OR	295.92	STERIS	1707248			84	Feb-17
ANES	123,659.00	SIEMENS - 20981	1704630			60	Feb-17
WIC	6,926.90	WB MASON	1704424			120	Feb-17
CLIN ENG	62,500.00	BAXTER	1706273			84	Feb-17
	34.00	BAXTER	1706273			84	Feb-17
WIC	29,077.00	STERLING SEC	1705797			60	Feb-17
	(5,577.00)					60	Feb-17
BARIATRICS	3,350.00	DISPLAY WRIGHT	1708051			180	Feb-17

WIC	3,500.00	DISPLAY WRIGHT	1708057			180	Feb-17
OR	9,994.95	KARL STORZ	1707452			84	Feb-17
IT	(7,451.29)	SIEMENS 3898	1612127	SCHEDULE 1	STRAIGHT	60	Feb-17
CENTRAL STI	(1,172.80)	CARDINAL HEALTH	1704227			120	Feb-17
RAD	12,085.02	MERGE	1704455			60	Mar-17
	12,085.02	MERGE	1704455			60	Mar-17
CLINICAL EN(	14,429.55	FLUKE	1706335			84	Mar-17
	(24.15)	FLUKE	1706335			84	Mar-17
SLEEP LAB	58,354.02	O AND G	1705880			120	Mar-17
SLEEP LAB	2,910.00	MOSER	1708476			120	Mar-17
SLEEP LAB	2,425.00	MOSER	1708062			120	Mar-17
PLANT	30,549.00	O AND G	1700873			120	Mar-17
	(2,000.00)	O AND G	1700873			120	Mar-17
WOUNDCARE	38,390.00	PERIMED	1705191			84	Mar-17
CENTRAL STI	16,816.50	WB MASON	1705901BL			120	Mar-17
OR	3,699.00	HAYDEN MED	1704106			84	Mar-17
FOOD	11,663.25	PERFORMANCE	1708641			60	Mar-17
IT	90,882.00	SIEMENS	160729			60	Mar-17
EMER	59,250.00	BAXTER	1706273			60	Mar-17
PLANT	12,429.54	GOODHILL	NA (MIKE)			120	Mar-17
OB4 ORTHO	4,769.08	PHILIPS	1706091			60	Mar-17
SH5 MED	2,384.54	PHILIPS	1706091			60	Mar-17
PLANT	5,198.20	VULCAN SEC	1708449			120	Mar-17
OR	9,994.95	KARL STORZ	1708952			84	Mar-17
CRITICAL CAI	7,179.29	PHILIPS	1706111			60	Mar-17
BIO MED	147,360.00	STRATASYS	1709090			60	Mar-17
CARD	22,940.00	CIVCO	1709562			10	Mar-17
WMUC	(12,727.08)	CHIANIS & ANDERSON	12780.33			240	Mar-17
	7,440,759.52						

Explanation	To be paid from
2 new Anesthesia Fabious Tiro machines	Operating cash
2 new patient monitors with easy care cuffs	Operating cash
new sterilization container w/accessories	Operating cash
new ISTAT 1 WIRELESS ANALYZER	Operating cash
new scopes and tray sterilization sterrads	Operating cash
VC- 10 VACUUM curettate system	Operating cash
new Bladder scan w/rolling cart	Operating cash
new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
SUTURE RETRIEVER ACCESSORIES	Operating cash
Sheath High flow arthroscopy & Hopkins scope	Operating cash
B3000 BLACK BADGE & BATTERIES	Operating cash
CO2 MONITOR & ACCESSORIES	Operating cash
Artic Sun 5000E Temp manage system & calibration test unit	Operating cash
20 monitors & 10 Optiplex 7040 SFF w/dual monitor stands	Operating cash
new bldg signage	Operating cash
replace condensing unit	Operating cash
HVAC duct CLEANING & SANTIZING	Operating cash
FIRE & SMOKE DAMPER	Operating cash
New Floor scrubbers (single & dual) and burnisher	Operating cash
deposit for DEHUMIDIFIER in TRAGER BASEMENT	Operating cash
depoisit for EXPANSION VALVE in TRAGER office	Operating cash
deposit for WALL COVERING in AUDITORIUM	Operating cash
AHU-1 Cooling coil replacement	Operating cash
CATH LAB # 2 RENOVATION	Operating cash
SLEEP LAB RENOVATION	Operating cash
Boardroom Project is now complete	Operating cash
4 each of 02 CS hoses & Air CS hoses 10FT Diss Hand	Operating cash
REVERSE OSMOSIS SYSTEM	Operating cash
2 Harmonyair G5 Dual Pkg Light systems	Operating cash
RECUMBENT CROSS TRAINER-the Foundation reimbursed us for this purchase	Foundation Funds
75 sterilization containers	Operating cash
TITANIUM GE MRI TOOL KIT	Operating cash
new LIPOSCULTPTOR handpiece & ACCESSORIES	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
CART, SINGLE TIER CORNER	Operating cash
CAMERA, CODER & STORAGE	Operating cash
VOLUSON P8	Operating cash
Board, Carbon fiber TTL ACS Radial	Operating cash
Security Alarm install	Operating cash
24 monitors & 12 Optiplex 7040 SFF w/dual monitor stands, plus software	Operating cash
MARKETING FURNITURE-chairs, credenza, tabletop, etc	Operating cash
interior painting from water damage	Operating cash

interior painting from water damage	Operating cash
Counter Fabrication	Operating cash
Prof srvs for FEASABILITY STUDY OPEN OFFICE	Operating cash
Labor & Materials for COUNTER TOPS THROUGHOUT HOSPITAL	Operating cash
Prof Srvs for AUDITORIUM RENOVATION	Operating cash
FIRE STOP Labor & Materials	Operating cash
MAIN MEGAWATT METER REPLACEMENT	Operating cash
EPOXY COATED SHOWER BASE	Operating cash
BLASIUS 2014 CHEVROLET CRUZE	Operating cash
SLEEP LAB RENOVATION	Operating cash
MEP-SLEEP LAB RENOVATION	Operating cash
RODI PIPING & INSTALL	Operating cash
SEER 1000	Operating cash
MAMMOTEST	Operating cash
EMERGENCY TEMP WALL	Operating cash
FURNISH & INSTALL CARPET & TILE	Operating cash
DAYCARE REMEDIATION	Operating cash
BRIO BEDSIDE CABINETS & OVERHEAD ART	Operating cash
AAON RTU GAS METERING	Operating cash
SYNGO DYNAMICS SYSTEM	Operating cash
REMOVE OLD HTP/ PUT NEW IN ITS PLACE	Operating cash
BRAINLAB OPTICAL	Operating cash
V500 WORKSTATIONS	Operating cash
SMART CARE MONITORING	Operating cash
AQUILLION PRIME 80	Operating cash
MOB 4TH FLOOR LOBBY	Operating cash
FLEX-X UTRETERSCOPE	Operating cash
SLEEP DESIGN MOB	Operating cash
CDIS MULTIGROUPING	Operating cash
LICENSE/ SUPPORT/ TRAINING	Operating cash
CARBON FIBER BOARD	Operating cash
TRANSDUCER CONVEX & LINEAR	Operating cash
OR ROOM REPAIRS	Operating cash
DEHUMIDIFIER INSTALL - TRAGER	Operating cash
VIDEO INTERCOM	Operating cash
SOFTWARE LICENSE FEES	Operating cash
DOOR ACCESS SYSTEM	Operating cash
HARMONY LIGHTS/ FP	Operating cash
CABLING	Operating cash
CABINET & SHELVES	Operating cash
FRAME NEW WALL	Operating cash
CABINETS	Operating cash
CIRCUIT FOR INBND/OUTBND SWITCHING	Operating cash
DISPOSABLE LINERS	Operating cash
PCKGO HEAT EXCHGE/PUMP REPLACEMENT	Operating cash
SLEEP LAB PROJECT	Operating cash

SLEEP LAB PROJECT	Operating cash
CARPET CHILD DEV	Operating cash
INTUITIVE ROBOT BUYOUT	Operating cash
EV100 CLINICAL PLTFM & SERVICE	Operating cash
EV100 CLINICAL PLTFM & SERVICE	Operating cash
FURNISH & INSTALL CARPET & TILE	Operating cash
FURNITURE	Operating cash
DOUBLE CATCH BASIN	Operating cash
911 PJT- BLOCK WINDOWS IN LAWLOR	Operating cash
911 PJT- CONSTRUCTION PROCESS	Operating cash
911 PJT- FLOORING VINYL	Operating cash
911 PJT- DUCTWORK & EXHAUST FANS INSTALL	Operating cash
911 PJT- ELECTRICAL CONTROLS	Operating cash
911 PJT- PAINTING STAIRWELLS	Operating cash
911 PJT- SECURITY WORK SPACE	Operating cash
911 PJT- STRIPPING AND WAXING FLOORS	Operating cash
911 PJT- INTERIOR SIGNS	Operating cash
911 PJT-ACCESS CONTROL SYSTEM	Operating cash
911 PJT-SPRINKLER HEADS	Operating cash
INTERIOR SIGN BRAILLE	Operating cash
V500 WORKSTATIONS	Operating cash
1320 WEST MAIN ADDITION	Operating cash
BOLLAND AT OXYGEN TANKS REMOVE & INSTALL	Operating cash
4 FT POS PRESS RECIRC COMP	Operating cash
HARMONY DUAL & SINGLE LIGHTING	Operating cash
DR TRAGER NEW FLOOR & FURNITURE	Operating cash
ULTRASOUND SPARQ	Operating cash
ATRION TELEPHONE SYSTEM	Operating cash
LIFE POLE W/LIFT & ASSIST	Operating cash
BRAVO RECEIVER/SOFTWARE/RECORDER	Operating cash
PROFESSIONAL DESIGN	Operating cash
TITAN 450 WATT ZENON LIGHT	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
CDIS TRAINNG/LICENSE	Operating cash
ATOMLAB 500 DOSE CALIB	Operating cash
ULTRAFIN LITHO STIRUP PAIR	Operating cash
IS4000 DA VINCI XI	Operating cash
STERRAD 100NX ™	Operating cash
SEER 1000	Operating cash
WEST MAIN TRANSFORMER RELOCATION	Operating cash
ROBOTIC CARRIER FOR NIGARA	Operating cash
FLOORING	Operating cash
BASE BID	Operating cash
CART W ACCESSORIES	Operating cash
PROFUSION UPGRADE	Operating cash
CADAVER LIFT CONVEYOR	Operating cash
ENTERAL SYRINGE PUMP	Operating cash

C0MPELLENT SC220 ENCLOSURE	Operating cash
POWER LED 175 LIGHT SOURCE	Operating cash
NVSC PAINTING (WATER DAMAGE)	Operating cash
HP DL380 G9 8GB RAM	Operating cash
HP DL380 G9 8GB RAM	Operating cash
LICENSE/ SOFTWARE/ SUPPORT	Operating cash
POWEREDGE R730 SERVER	Operating cash
SHELVING	Operating cash
SHELVING	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
COMPELLENT SC220 ENCLOSURE	Operating cash
WEST MAIN ADDITION	Operating cash
TRUSYSTEM 7000DV & ROBOTIC PKG	Operating cash
MOB SLEEP LAB RENOVATION	Operating cash
PARKING GARAGE ASSESSMENT CONDITION	Operating cash
LIGHTING UPGRADE	Operating cash
SUNQUEST PJT/ TV, DESK,ACCESS	Operating cash
SUNQUEST PJT/ TV, DESK,ACCESS	Operating cash
OR LIGHT SUPPORT SYSTEM	Operating cash
SHIMADZU PORTABLE X-RAY	Operating cash
WALLS IN SLEEP LAB	Operating cash
GAS CHARBOILER	Operating cash
WARMING CABINET #5524	Operating cash
MOB 4TH FL LOBBY NEW WALL & DOOR	Operating cash
FIRE ALARM PANEL	Operating cash
O'BRIEN PLUMBING	Operating cash
PACEMAKER EXTERNAL	Operating cash
AQUILION CT SCAN PYMT	Operating cash
MONITORS, CAMERAS, LIGHT PKG	Operating cash
LICENSE/ SUPPORT/ TRAINING	Operating cash
TABLE MOTION UPGRADE	Operating cash
FLOORING	Operating cash
FLOORING	Operating cash
GAS CHARBOILER INSTALL	Operating cash
SERVERS	Operating cash
PROFESSIONAL SERVICES WMUC	Operating cash
FIBROSCAN 502 TOUCH	Operating cash
LIGHT HANDLE CAMERA COVER	Operating cash
ACUSON SC2000 MAINFRAME	Operating cash
CHAIRS, ALL STEEL TASK	Operating cash
SPECTRUM IV PUMPS	Operating cash
SPECTRUM IV PUMPS	Operating cash
ADDITIONAL CAMERAS	Operating cash
ADDITIONAL CAMERAS	Operating cash
SHELVING & CABINETS	Operating cash

BASE CABINET & COUNTERTOPS	Operating cash
URETERSCOPE FLEXIBLE	Operating cash
SYNGO DYNAMICS SYSTEM	Operating cash
CART W ACCESSORIES	Operating cash
SOFTWARE SERVICES	Operating cash
SOFTWARE SERVICES	Operating cash
INFUSION ANALYZER	Operating cash
INFUSION ANALYZER	Operating cash
APPLICATION & CERTIFICATE	Operating cash
ARCHITECTUAL/MEP	Operating cash
ARCHITECTUAL/MEP	Operating cash
TRIAGE PROJECT	Operating cash
TRIAGE PROJECT	Operating cash
PF6001 MAIN UNIT	Operating cash
FLOORING/INSTALL	Operating cash
MARTINS ARM RETRACTOR	Operating cash
ESPRESSO MACHINE	Operating cash
UPGRADE VIRTUAL SIS SERVER	Operating cash
SPECTRUM IV PUMPS	Operating cash
PIPE TESTING PJT 911	Operating cash
MONITOR DEMOSURE SIGNVS4	Operating cash
MONITOR DEMOSURE SIGNVS4	Operating cash
DEPT OF MEDICINE DOOR	Operating cash
FLEX-X URETERSCOPE	Operating cash
INTELLIVUE MULTI SERVER	Operating cash
PRINTER CONNEX 3D	Operating cash
ASTER TEE (WATER & AIR) SYSTEM	Operating cash
PROFESSIONAL SERVICES WMUC	Operating cash

Acct #	Project Name
1600-0001	CIP Holding
1600-0002	Oncology Center Project
1600-0003	MRI Project
1600-0004	Atrion Project
1600-0005	Cheshire Project
1600-0006	Northwest 911 Project
1600-0007	Cardiac Cath Lab Project
1600-0008	Naugatuck Urgent Care
1600-0009	EPIC Project
1600-0010	East Main Street Urgent Care
1600-0011	Wound Care Lobby
1600-0012	Ambulatory Pavillion
1600-0013	West Main Street Urgent Care

Project Description	Balance as of 7/31/16	Aug-Sep Additions
CIP Holding	448,951.00	(445,893.03)
Renovations to Dr Bowen's office located in the HLRCC	495,723.17	145,129.30
Renovations to new MRI area and Behavoiral Health in Emer Rm - 4 Phases to project	3,387,211.50	588,798.05
Phase I of new phone system project	529,483.69	38,021.76
New construction for a Cheshire Urgent Care Ctr and a Primary Care/Specialty Practice	411,202.86	1,173,005.58
Renovations to 2nd floor of Lawlor Bldg for 911 Call Center	342,014.94	6,475.00
Renovations for a new Cardiac Cath Lab	1,680.00	647,552.69
Construction for a new Urgent Care Ctr in Naugatuck - Project was put off until after FY2017, expenses were for Architect designs	7,377.50	3,688.75
Project to convert our systems to EPIC to be consistent with Trinity Systems	-	-
Construction for a new Urgent Care Ctr in Waterbury located near Costco	-	-
Renovations to the Wound Care Lobby	-	-
Construction of new Ambulatory Pavillion	-	-
Renovations to West Main Street Urgent Care - Additions	-	-

Balance as of 9/30/16	Oct-Mar Additions	Balance as of 3/31/17	Project Start Date	Project expected end date	Project Budget
3,057.97	1,202.03	4,260.00			
640,852.47	568,487.73	1,209,340.20	Apr-16	FY 2017	940,000
3,976,009.55	818,747.88	4,794,757.43	Sep-15	Jun-17	5,800,000
567,505.45	(567,505.45)	-	Jan-16	Nov-16	567,505
1,584,208.44	323,873.45	1,908,081.89	Mar-16	FY 2017	2,320,388
348,489.94	(348,489.94)	-	Feb-16	Nov-16	250,000
649,232.69	41,566.49	690,799.18	May-16	FY 2017	815,823
11,066.25	41,884.50	52,950.75	FY 2018	FY 2019	2,100,000
-	2,638,475.44	2,638,475.44	Oct-16	FY 2018	20,000,000
-	588,004.49	588,004.49	Jan-17	Jul-17	3,400,000
-	6,273.90	6,273.90	Mar-17	FY 2017	49,750
-	48,528.48	48,528.48	Jan-17	FY 2019	38,000,000
-	14,495.27	14,495.27	Mar-17	FY 2018	585,000

To be paid from

Operating cash
Operating cash
Operating cash, plus a 767,013 from a State grant
Operating cash

Operating cash

Operating cash
Operating cash

Operating cash

Operating cash & possible loan from Trinity

Operating cash

Operating Cash
Needs Approval
Operating Cash

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 21,111,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**19,210,000**
Bad debts	**8,642,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,682,000**
Equity transfer	**340,000**
Changes in:	
Accounts receivable--patients, net	**(28,171,000)**
Due from affiliated entities	**10,492,000**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(51,000)**
Prepaid expenses	**1,064,000**
Other assets	**(2,266,000)**
Accounts payable	**(3,539,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(6,747,000)**
Due to third party reimbursement agencies	**(1,444,000)**
Other current liabilities	**719,000**
Accrued pension and retiree health costs	**(18,003,000)**
Other long term liabilities	**800,000**
Net cash provided by operating activities	**10,819,000**
Investing activities:	
Purchases of property, plant and equipment, net	**(23,528,000)**
Decrease in assets whose use is limited	**(1,814,000)**
Decrease in investments	**14,854,000**
Net cash used in investing activities	**(10,488,000)**
Financing activities	
Principal payments on long-term debt	**(2,750,000)**
Net cash used in financing activities	**(2,750,000)**
Net decrease in cash and cash equivalents	**(2,419,000)**
Cash and cash equivalents at beginning of period	**17,282,000**
Cash and cash equivalents at end of period	**14,863,000**

TRINITY HEALTH - NEW ENGLAND, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	Six Months Ended March 31 2017
Operating activities:	
Increase in net assets	**$ 14,628,000**
Adjustments to reconcile change in net assets to net cash used in operating activities:	
Depreciation and amortization	**30,251,000**
Bad debts	**16,997,000**
Unrealized and realized gains on investment	**1,142,000**
Restricted contributions and investment income	**2,738,000**
Equity transfer	**(5,433,000)**
Changes in:	
Accounts receivable--patients, net	**(30,659,000)**
Due from affiliated entities	**(3,334,000)**
Due from third party reimbursement agencies	**4,838,000**
Inventory of supplies	**(926,000)**
Prepaid expenses	**1,178,000**
Other assets	**682,000**
Accounts payable	**(4,606,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,710,000)**
Due to third party reimbursement agencies	**251,000**
Other current liabilities	**1,488,000**
Accrued pension and retiree health costs	**(25,380,000)**
Other long term liabilities	**(17,282,000)**
Net cash used in operating activities	**(21,137,000)**
Investing activities:	
Purchases of property, plant and equipment, net	**(36,404,000)**
Decrease in assets whose use is limited	**24,823,000**
Decrease in investments	**12,909,000**
Net cash provided by investing activities	**1,328,000**
Financing activities	
Principal payments on long-term debt	**(3,040,000)**
Net cash used in financing activities	**(3,040,000)**
Net decrease in cash and cash equivalents	**(22,849,000)**
Cash and cash equivalents at beginning of period	**72,316,000**
Cash and cash equivalents at end of period	**49,467,000**

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$2,300
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$1,664
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$226
H.	Malpractice Insurance Cost	$650
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$219
	Total savings 10/1-3/31	$5,059

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended March 31, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health – New England, Inc. In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $30,000 for the six month period ended March 31, 2017.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million. Savings realized for the six month period ended March 31, 2017 of $114,000. Furthermore, additional insurance premium savings of $198,000 will be realized for the annual period 7/1/2017 through 6/30/2018.

There have been significant efforts to centralize support functions across Trinity Health-New England including Finance, Revenue Cycle, and Information Systems. This has resulted in reduction of costs at Johnson of $720,000 for the six months ended March 31, 2017.

In addition, Johnson has benefited from the utilization of both regional and system office Legal Services, Compliance and Audit departments. The decrease in legal fees, consulting and auditing costs associated with this transition was $615,000 for the six month period ended March 31, 2017.

Non-salary information technology costs of $308,000 were transferred to the region at the beginning of FY 2017. Other cost reductions due to regionalization were $47,000 and $43,000 in advertising and recruitment expenses. Johnson's portion of these costs are now included in the regional allocation.

The above savings are offset by a regional allocation of $639,660 for the six month period included in other operating expenses in **Attachment A.**

During the first calendar quarter of 2017, the Enfield Oncology staff transitioned to employees of Saint Francis. This transition allows both Saint Francis and Johnson to share resources across both campuses, provide enhanced compensation packages for employees and has resulted in a lower cost to Johnson through this arrangement. Annual savings associated with this staffing restructure is $137,000 and $86,000 was realized for the six month period ended March 31, 2017.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health-New England and Trinity Health in each of the areas identified above.

Interest and insurance savings related to JMMC are included in the amounts described above. There are no additional cost savings within JMMC.

Johnson transitioned to the Trinity Total Rewards program for employee compensation and benefits. Johnson provided its employees with a 2% pay increase on September 1st. Effective 1/1/2017, Johnson employees are participating in Trinity Health's defined contribution plan which provides for a core employer contribution for all employees and matching contributions funded bi-weekly for those employees who make deferrals into the plan. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Lastly, Trinity Health – New England, Inc. (TH – NE) working with Trinity Health has engaged consultants to continue to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.0 million benefit to the Connecticut hospitals within TH - NE.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. Supply chain savings Savings realized during the six month period was $75,000.

See **Attachment A** for expense savings by category. Also, refer to financial statistics noting significant improvement in financial performance since the acquisition of Johnson by TH – NE.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining Trinity Health – New England, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. Areas of clinical quality improvement have been in decreased sepsis in readmission rates, and a reduction in serious safety events were marginal.

Also, Johnson's average daily census and year to date discharges continue to remain strong and Johnson's overall financial performance has improved significantly since the affiliation.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 10/1/2016-3/31/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$1,675
B.	Fringe Benefits (workers comp)	$335
C.	Contractual Labor Fees	($1,204)
D.	Medical Supplies and Pharmaceutical Cost	$75
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$30
H.	Malpractice Insurance Cost	
I.	Utilities	
J.	Business Expenses (insurance)	$114
K.	Other Operating Expense	$373
	Total savings 10/1/2016-3/31/2017	$1,398

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$85,944	$369,304	$283,360	330%
2	Short Term Investments	$1,610,228	$1,396,623	($213,605)	-13%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$9,060,046	($8,356,653)	-48%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$1,717,728	$204,255	13%
8	Prepaid Expenses	$676,712	$694,419	$17,707	3%
9	Other Current Assets	$3,525,137	$2,632,601	($892,536)	-25%
	Total Current Assets	**$24,828,193**	**$15,870,721**	**($8,957,472)**	**-36%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,180,806	($21,359)	-1%
7	Other Noncurrent Assets	$805,530	$693,519	($112,011)	-14%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$26,423,836	$5,676,661	27%
2	Less: Accumulated Depreciation	$861,533	$2,364,255	$1,502,722	174%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,059,581**	**$4,173,939**	**21%**
3	Construction in Progress	$870,370	$88,188	($782,182)	-90%
	Total Net Fixed Assets	**$20,756,012**	**$24,147,769**	**$3,391,757**	**16%**
	Total Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$3,250,101	($1,232,369)	-27%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,527,469	$37,957	2%
3	Due To Third Party Payers	$843,823	$1,538,891	$695,068	82%
4	Due To Affiliates	$23,268,975	$10,527,920	($12,741,055)	-55%
5	Current Portion of Long Term Debt	$388,912	$392,827	$3,915	1%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$531,683	$469,090	($62,593)	-12%
	Total Current Liabilities	**$32,005,375**	**$18,706,298**	**($13,299,077)**	**-42%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$22,258,008	$21,525,532	($732,476)	-3%
3	Other Long Term Debt	$0	$0	$0	0%
	Total Long Term Debt	**$22,258,008**	**$21,525,532**	**($732,476)**	**-3%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$954,733	$1,000,286	$45,553	5%
	Total Long Term Liabilities	**$23,212,741**	**$22,525,818**	**($686,923)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,084,231	$8,252,920	-134%
2	Temporarily Restricted Net Assets	$542,473	$576,468	$33,995	6%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$2,660,699**	**$8,286,915**	**-147%**
	Total Liabilities and Net Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$168,025,861	$87,365,340	($80,660,521)	-48%
2	Less: Allowances	$106,771,249	$53,863,364	($52,907,885)	-50%
3	Less: Charity Care	$160,880	$73,514	($87,366)	-54%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$61,093,732**	**$33,428,462**	**($27,665,270)**	**-45%**
5	Provision for Bad Debts	$1,977,084	$1,137,539	($839,545)	-42%
	Net Patient Service Revenue less provision for bad debts	**$59,116,648**	**$32,290,923**	**($26,825,725)**	**-45%**
6	Other Operating Revenue	$2,726,640	$634,205	($2,092,435)	-77%
7	Net Assets Released from Restrictions	$18,000	$23,149	$5,149	29%
	Total Operating Revenue	**$61,861,288**	**$32,948,277**	**($28,913,011)**	**-47%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$25,747,624	$11,734,864	($14,012,760)	-54%
2	Fringe Benefits	$6,228,877	$2,764,667	($3,464,210)	-56%
3	Physicians Fees	$5,219,086	$1,363,342	($3,855,744)	-74%
4	Supplies and Drugs	$10,205,613	$5,686,294	($4,519,319)	-44%
5	Depreciation and Amortization	$3,012,066	$1,288,094	($1,723,972)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$913,249	$420,217	($493,032)	-54%
8	Malpractice Insurance Cost	$293,627	($27,394)	($321,021)	-109%
9	Other Operating Expenses	$15,310,826	$9,319,622	($5,991,204)	-39%
	Total Operating Expenses	**$66,930,968**	**$32,549,706**	**($34,381,262)**	**-51%**
	Income/(Loss) From Operations	**($5,069,680)**	**$398,571**	**$5,468,251**	**-108%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$33,526	$0	($33,526)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($241,788)	($48,615)	$193,173	-80%
	Total Non-Operating Revenue	**($208,262)**	**($48,615)**	**$159,647**	**-77%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($5,277,942)**	**$349,956**	**$5,627,898**	**-107%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	($605,078)	$0	$605,078	-100%
	Total Other Adjustments	**($605,078)**	**$0**	**$605,078**	**-100%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expense	($5,883,020)	$349,956	$6,232,976	-106%

Johnson Memorial Hospital

	Mar 17 YTD	Sept16* YTD	Comments
Monthly Financial Measurement/Indicators			
A. Operating Performance:			
Operating Margin	1.2%	-7.0%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	6.4%	-0.5%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.3%	1.0%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	15.5	9.9	(cash and cash equiv+board restr. cash)/(total exp-depr)/YT
Days in Net Accounts Receivables	76.9	109.4	net ar/net patient ser rev/days in yr
Average Payment Period	164.0	186.9	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	823.7%	-402.5%	total debt/total equity(net assets)
Long-term Debt to Capitalization	89.0%	133.8%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.1%	7.5%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	2.0	(4.5)	EBIT/Interest expense
Debt Service Coverage Ratio	2.59 x	-0.3 x	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	6.1%	-11.3%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations*	$ 399	$ (3,214)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 350	$ (3,474)	Net gain(loss)
EBIDA	$ 2,107	$ (247)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,766	$ 1,696	from bs
Net Working Capital	$ (2,835)	$ (7,177)	current assets-current liabilities
Unrestricted Assets	$ 2,084	$ (6,169)	from bs

*reflects 01/16-09/30/16

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$85,944	$369,304	$283,360	330%
2	Short Term Investments	$1,610,228	$1,396,623	($213,605)	-13%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$9,060,046	($8,356,653)	-48%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$1,717,728	$204,255	13%
8	Prepaid Expenses	$676,712	$694,419	$17,707	3%
9	Other Current Assets	$3,525,137	$2,632,601	($892,536)	-25%
	Total Current Assets	**$24,828,193**	**$15,870,721**	**($8,957,472)**	**-36%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,180,806	($21,359)	-1%
7	Other Noncurrent Assets	$805,530	$693,519	($112,011)	-14%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$26,423,836	$5,676,661	27%
2	Less: Accumulated Depreciation	$861,533	$2,364,255	$1,502,722	174%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,059,581**	**$4,173,939**	**21%**
3	Construction in Progress	$870,370	$88,188	($782,182)	-90%
	Total Net Fixed Assets	**$20,756,012**	**$24,147,769**	**$3,391,757**	**16%**
	Total Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
1	Accounts Payable and Accrued Expenses	$4,482,470	$3,250,101	($1,232,369)	-27%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,527,469	$37,957	2%
3	Due To Third Party Payers	$843,823	$1,538,891	$695,068	82%
4	Due To Affiliates	$23,268,975	$10,527,920	($12,741,055)	-55%
5	Current Portion of Long Term Debt	$388,912	$392,827	$3,915	1%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$531,683	$469,090	($62,593)	-12%
	Total Current Liabilities	**$32,005,375**	**$18,706,298**	**($13,299,077)**	**-42%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$22,258,008	$21,525,532	($732,476)	-3%
3	Other Long Term Debt	$0	$0	$0	0%
	Total Long Term Debt	**$22,258,008**	**$21,525,532**	**($732,476)**	**-3%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$954,733	$1,000,286	$45,553	5%
	Total Long Term Liabilities	**$23,212,741**	**$22,525,818**	**($686,923)**	**-3%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,084,231	$8,252,920	-134%
2	Temporarily Restricted Net Assets	$542,473	$576,468	$33,995	6%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$2,660,699**	**$8,286,915**	**-147%**
	Total Liabilities and Net Assets	**$49,591,900**	**$43,892,815**	**($5,699,085)**	**-11%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$168,025,861	$87,365,340	($80,660,521)	-48%
2	Less: Allowances	$106,771,249	$53,863,364	($52,907,885)	-50%
3	Less: Charity Care	$160,880	$73,514	($87,366)	-54%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$61,093,732**	**$33,428,462**	**($27,665,270)**	**-45%**
5	Provision for Bad Debts	$1,977,084	$1,137,539	($839,545)	-42%
	Net Patient Service Revenue less provision for bad debts	**$59,116,648**	**$32,290,923**	**($26,825,725)**	**-45%**
6	Other Operating Revenue	$2,726,640	$634,205	($2,092,435)	-77%
7	Net Assets Released from Restrictions	$18,000	$23,149	$5,149	29%
	Total Operating Revenue	**$61,861,288**	**$32,948,277**	**($28,913,011)**	**-47%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$25,747,624	$11,734,864	($14,012,760)	-54%
2	Fringe Benefits	$6,228,877	$2,764,667	($3,464,210)	-56%
3	Physicians Fees	$5,219,086	$1,363,342	($3,855,744)	-74%
4	Supplies and Drugs	$10,205,613	$5,686,294	($4,519,319)	-44%
5	Depreciation and Amortization	$3,012,066	$1,288,094	($1,723,972)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$913,249	$420,217	($493,032)	-54%
8	Malpractice Insurance Cost	$293,627	($27,394)	($321,021)	-109%
9	Other Operating Expenses	$15,310,826	$9,319,622	($5,991,204)	-39%
	Total Operating Expenses	**$66,930,968**	**$32,549,706**	**($34,381,262)**	**-51%**
	Income/(Loss) From Operations	**($5,069,680)**	**$398,571**	**$5,468,251**	**-108%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$33,526	$0	($33,526)	-100%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($241,788)	($48,615)	$193,173	-80%
	Total Non-Operating Revenue	**($208,262)**	**($48,615)**	**$159,647**	**-77%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($5,277,942)**	**$349,956**	**$5,627,898**	**-107%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	($605,078)	$0	$605,078	-100%
	Total Other Adjustments	**($605,078)**	**$0**	**$605,078**	**-100%**
	Excess/(Deficiency) of Revenue Over Expense	**($5,883,020)**	**$349,956**	**$6,232,976**	**-106%**

JOHNSON MEMORIAL HOSPITAL

NINE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

31-Mar-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
I.	**ASSETS**			
A.	**Current Assets:**			
1	Cash and Cash Equivalents	$20,572,000	$19,853,000	($719,000)
2	Short Term Investments	$23,000	$0	($23,000)
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$26,298,000	$27,705,000	$1,407,000
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0
5	Due From Affiliates	$0	$0	$0
6	Due From Third Party Payers	$0	$0	$0
7	Inventories of Supplies	$3,889,000	$4,559,000	$670,000
8	Prepaid Expenses	$2,930,000	$2,561,000	($369,000)
9	Other Current Assets	$3,114,000	$2,185,000	($929,000)
	Total Current Assets	**$56,826,000**	**$56,863,000**	**$37,000**
B.	**Noncurrent Assets Whose Use is Limited:**			
1	Held by Trustee	$15,480,000	$15,681,000	$201,000
2	Board Designated for Capital Acquisition	$0	$0	$0
3	Funds Held in Escrow	$0	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$6,000	$6,000	$0
	Total Noncurrent Assets Whose Use is Limited:	**$15,486,000**	**$15,687,000**	**$201,000**
5	Interest in Net Assets of Foundation	$5,549,000	$5,810,000	$261,000
6	Long Term Investments	$10,973,000	$11,487,000	$514,000
7	Other Noncurrent Assets	$25,740,000	$10,565,000	($15,175,000)
C.	**Net Fixed Assets:**			
1	Property, Plant and Equipment	$91,358,000	$97,843,000	$6,485,000
2	Less: Accumulated Depreciation	$2,656,000	$10,694,000	$8,038,000
	Property, Plant and Equipment, Net	**$88,702,000**	**$87,149,000**	**($1,553,000)**
3	Construction in Progress	$7,780,000	$11,956,000	$4,176,000
	Total Net Fixed Assets	**$96,482,000**	**$99,105,000**	**$2,623,000**
	Total Assets	**$211,056,000**	**$199,517,000**	**($11,539,000)**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

31-Mar-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**			
A.	**Current Liabilities:**			
1	Accounts Payable and Accrued Expenses	$15,420,000	$18,915,000	$3,495,000
2	Salaries, Wages and Payroll Taxes	$5,045,000	$4,123,000	($922,000)
3	Due To Third Party Payers	$1,262,000	$416,000	($846,000)
4	Due To Affiliates	$0	$0	$0
5	Current Portion of Long Term Debt	$89,000	$0	($89,000)
6	Current Portion of Notes Payable	$0	$0	$0
7	Other Current Liabilities	$15,913,000	$11,558,000	($4,355,000)
	Total Current Liabilities	**$37,729,000**	**$35,012,000**	**($2,717,000)**
B.	**Long Term Debt:**			
1	Bonds Payable (Net of Current Portion)	$0	$0	$0
2	Notes Payable (Net of Current Portion)	$0	$0	$0
	Total Long Term Debt	**$0**	**$0**	**$0**
3	Accrued Pension Liability	$83,306,000	$80,137,000	($3,169,000)
4	Other Long Term Liabilities	$9,341,000	$8,303,000	($1,038,000)
	Total Long Term Liabilities	**$92,647,000**	**$88,440,000**	**($4,207,000)**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0
C.	**Net Assets:**			
1	Unrestricted Net Assets or Equity	$62,162,000	$57,279,000	($4,883,000)
2	Temporarily Restricted Net Assets	$1,970,000	$2,055,000	$85,000
3	Permanently Restricted Net Assets	$16,548,000	$16,731,000	$183,000
	Total Net Assets	**$80,680,000**	**$76,065,000**	**($4,615,000)**
	Total Liabilities and Net Assets	**$211,056,000**	**$199,517,000**	**($11,539,000)**

(6)
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(6) % DIFFERENCE
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-5%

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$406,827,000	$440,801,000	$33,974,000
2	Less: Allowances	$268,852,000	$300,974,000	$32,122,000
3	Less: Charity Care	$855,000	$2,834,000	$1,979,000
4	Less: Other Deductions	$0	$0	$0
	Total Net Patient Revenue	**$137,120,000**	**$136,993,000**	**($127,000)**
5	Provision for Bad Debts	$4,961,000	$3,494,000	($1,467,000)
	Net Patient Service Revenue less provision for bad debts	**$132,159,000**	**$133,499,000**	**$1,340,000**
6	Other Operating Revenue	$5,743,000	$4,849,000	($894,000)
7	Net Assets Released from Restrictions	$0	$0	$0
	Total Operating Revenue	**$137,902,000**	**$138,348,000**	**$446,000**
B.	**Operating Expenses:**			
1	Salaries and Wages	$45,110,000	$48,444,000	$3,334,000
2	Fringe Benefits	$14,267,000	$7,923,000	($6,344,000)
3	Physicians Fees	$9,153,000	$7,176,000	($1,977,000)
4	Supplies and Drugs	$22,612,000	$23,419,000	$807,000
5	Depreciation and Amortization	$5,737,000	$8,042,000	$2,305,000
6	Bad Debts	$0	$0	$0
7	Interest Expense	$119,000	$2,000	($117,000)
8	Malpractice Insurance Cost	$2,351,000	$1,560,000	($791,000)
9	Other Operating Expenses	$25,121,000	$26,618,000	$1,497,000
	Total Operating Expenses	**$124,470,000**	**$123,184,000**	**($1,286,000)**
	Income/(Loss) From Operations	**$13,432,000**	**$15,164,000**	**$1,732,000**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$218,000	$490,000	$272,000
2	Gifts, Contributions and Donations		$0	$0
3	Other Non-Operating Gains/(Losses)	$55,000	$50,000	($5,000)
	Total Non-Operating Revenue	**$273,000**	**$540,000**	**$267,000**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$13,705,000**	**$15,704,000**	**$1,999,000**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expenses	$13,705,000	$15,704,000	$1,999,000

(6) % DIFFERENCE
8%
12%
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-16%
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15%
0%
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(6)
%
DIFFERENCE
15%

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

31-Mar-16

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
I.	**ASSETS**			
A.	**Current Assets:**			
1	Cash and Cash Equivalents	$22,818,000	$22,077,000	($741,000)
2	Short Term Investments	$23,000	$0	($23,000)
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$30,634,000	$32,040,000	$1,406,000
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$0	($3,418,000)
5	Due From Affiliates	$0	$0	$0
6	Due From Third Party Payers	$0	$0	$0
7	Inventories of Supplies	$3,889,000	$4,560,000	$671,000
8	Prepaid Expenses	$3,515,000	$2,998,000	($517,000)
9	Other Current Assets	$3,192,000	$2,200,000	($992,000)
	Total Current Assets	**$67,489,000**	**$63,875,000**	**($3,614,000)**
B.	**Noncurrent Assets Whose Use is Limited:**			
1	Held by Trustee	$15,480,000	$15,681,000	$201,000
2	Board Designated for Capital Acquisition	$0	$0	$0
3	Funds Held in Escrow	$0	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$19,537,000	$6,000	($19,531,000)
	Total Noncurrent Assets Whose Use is Limited:	**$35,017,000**	**$15,687,000**	**($19,330,000)**
5	Interest in Net Assets of Foundation	$0	$0	$0
6	Long Term Investments	$15,428,000	$16,137,000	$709,000
7	Other Noncurrent Assets	$6,263,000	$9,726,000	$3,463,000
C.	**Net Fixed Assets:**			
1	Property, Plant and Equipment	$95,973,000	$102,544,000	$6,571,000
2	Less: Accumulated Depreciation	$2,835,000	$11,477,000	$8,642,000
	Property, Plant and Equipment, Net	**$93,138,000**	**$91,067,000**	**($2,071,000)**
3	Construction in Progress	$7,873,000	$12,062,000	$4,189,000
	Total Net Fixed Assets	**$101,011,000**	**$103,129,000**	**$2,118,000**
	Total Assets	**$225,208,000**	**$208,554,000**	**($16,654,000)**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

31-Mar-16

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**			
A.	**Current Liabilities:**			
1	Accounts Payable and Accrued Expenses	$16,465,000	$19,545,000	$3,080,000
2	Salaries, Wages and Payroll Taxes	$8,160,000	$6,515,000	($1,645,000)
3	Due To Third Party Payers	$1,262,000	$416,000	($846,000)
4	Due To Affiliates	$0	$0	$0
5	Current Portion of Long Term Debt	$337,000	$228,000	($109,000)
6	Current Portion of Notes Payable	$0	$0	$0
7	Other Current Liabilities	$13,842,000	$12,603,000	($1,239,000)
	Total Current Liabilities	**$40,066,000**	**$39,307,000**	**($759,000)**
B.	**Long Term Debt:**			
1	Bonds Payable (Net of Current Portion)	$0	$0	$0
2	Notes Payable (Net of Current Portion)	$586,000	$514,000	($72,000)
	Total Long Term Debt	**$586,000**	**$514,000**	**($72,000)**
3	Accrued Pension Liability	$83,306,000	$80,137,000	($3,169,000)
4	Other Long Term Liabilities	$21,395,000	$9,203,000	($12,192,000)
	Total Long Term Liabilities	**$105,287,000**	**$89,854,000**	**($15,433,000)**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,588,000	$2,479,000	($109,000)
C.	**Net Assets:**			
1	Unrestricted Net Assets or Equity	$58,749,000	$58,128,000	($621,000)
2	Temporarily Restricted Net Assets	$1,970,000	$2,055,000	$85,000
3	Permanently Restricted Net Assets	$16,548,000	$16,731,000	$183,000
	Total Net Assets	**$77,267,000**	**$76,914,000**	**($353,000)**
	Total Liabilities and Net Assets	**$225,208,000**	**$208,554,000**	**($16,654,000)**

(6) % DIFFERENCE
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(6) % DIFFERENCE
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SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$454,966,000	$491,688,000	$36,722,000
2	Less: Allowances	$297,453,000	$330,877,000	$33,424,000
3	Less: Charity Care	$855,000	$2,834,000	$1,979,000
4	Less: Other Deductions	$0	$0	$0
	Total Net Patient Revenue	**$156,658,000**	**$157,977,000**	**$1,319,000**
5	Provision for Bad Debts	$5,798,000	$4,885,000	($913,000)
	Net Patient Service Revenue less provision for bad debts	**$150,860,000**	**$153,092,000**	**$2,232,000**
6	Other Operating Revenue	$6,156,000	$5,429,000	($727,000)
7	Net Assets Released from Restrictions	$0	$0	$0
	Total Operating Revenue	**$157,016,000**	**$158,521,000**	**$1,505,000**
B.	**Operating Expenses:**			
1	Salaries and Wages	$64,454,000	$69,508,000	$5,054,000
2	Fringe Benefits	$16,909,000	$10,886,000	($6,023,000)
3	Physicians Fees	$9,294,000	$7,401,000	($1,893,000)
4	Supplies and Drugs	$23,572,000	$24,435,000	$863,000
5	Depreciation and Amortization	$6,107,000	$8,676,000	$2,569,000
6	Bad Debts	$0	$0	$0
7	Interest Expense	$128,000	$22,000	($106,000)
8	Malpractice Insurance Cost	$3,343,000	$2,368,000	($975,000)
9	Other Operating Expenses	$29,484,000	$31,355,000	$1,871,000
	Total Operating Expenses	**$153,291,000**	**$154,651,000**	**$1,360,000**
	Income/(Loss) From Operations	**$3,725,000**	**$3,870,000**	**$145,000**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$218,000	$490,000	$272,000
2	Gifts, Contributions and Donations		$0	$0
3	Other Non-Operating Gains/(Losses)	$55,000	$50,000	($5,000)
	Total Non-Operating Revenue	**$273,000**	**$540,000**	**$267,000**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$3,998,000**	**$4,410,000**	**$412,000**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

6 MONTHS ENDED MARCH 31, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
		FY 2016	FY 2017	AMOUNT
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE
	Excess/(Deficiency) of Revenue Over Expenses	$3,998,000	$4,410,000	$412,000

(6) % DIFFERENCE
8%
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(6)
%
DIFFERENCE
10%

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	MARCH	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$14,863,000	($2,419,000)	-14%
2	Short Term Investments	$37,626,000	$22,759,000	($14,867,000)	-40%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$84,118,000	$19,529,000	30%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$36,994,000	($10,492,000)	-22%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$8,913,000	$8,964,000	$51,000	1%
8	Prepaid Expenses	$3,861,000	$2,797,000	($1,064,000)	-28%
9	Other Current Assets	$3,498,000	$3,950,000	$452,000	13%
	Total Current Assets	**$188,768,000**	**$175,120,000**	**($13,648,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$55,311,000	$56,453,000	$1,142,000	2%
2	Board Designated for Capital Acquisition	$42,931,000	$45,721,000	$2,790,000	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$0	($2,118,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$102,174,000**	**$1,814,000**	**2%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,935,000	($2,331,000)	-18%
6	Long Term Investments	$48,717,000	$51,061,000	$2,344,000	5%
7	Other Noncurrent Assets	$7,050,000	$8,864,000	$1,814,000	26%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$428,235,000	$9,424,000	2%
2	Less: Accumulated Depreciation	$43,734,000	$62,758,000	$19,024,000	43%
	Property, Plant and Equipment, Net	**$375,077,000**	**$365,477,000**	**($9,600,000)**	**-3%**
3	Construction in Progress	$14,905,000	$28,823,000	$13,918,000	93%
	Total Net Fixed Assets	**$389,982,000**	**$394,300,000**	**$4,318,000**	**1%**
	Total Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$30,624,000	($3,539,000)	-10%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,397,000	($6,747,000)	-18%
3	Due To Third Party Payers	$8,953,000	$7,509,000	($1,444,000)	-16%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$6,690,000	($235,000)	-3%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$9,764,000	$719,000	8%
	Total Current Liabilities	**$97,230,000**	**$85,984,000**	**($11,246,000)**	**-12%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$235,217,000	($2,515,000)	-1%
	Total Long Term Debt	**$237,732,000**	**$235,217,000**	**($2,515,000)**	**-1%**
3	Accrued Pension Liability	$227,408,000	$209,405,000	($18,003,000)	-8%
4	Other Long Term Liabilities	$51,868,000	$52,668,000	$800,000	2%
	Total Long Term Liabilities	**$517,008,000**	**$497,290,000**	**($19,718,000)**	**-4%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$70,673,000	$21,451,000	44%
2	Temporarily Restricted Net Assets	$29,372,000	$32,054,000	$2,682,000	9%
3	Permanently Restricted Net Assets	$55,311,000	$56,453,000	$1,142,000	2%
	Total Net Assets	**$133,905,000**	**$159,180,000**	**$25,275,000**	**19%**
	Total Liabilities and Net Assets	**$748,143,000**	**$742,454,000**	**($5,689,000)**	**-1%**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 OCT -MAR	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,000	$1,225,669,000	($1,026,535,000)	-46%
2	Less: Allowances	$1,498,710,000	$828,362,000	($670,348,000)	-45%
3	Less: Charity Care	$8,463,000	$9,103,000	$640,000	8%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,000**	**$388,204,000**	**($356,827,000)**	**-48%**
5	Provision for Bad Debts	$14,575,000	$8,642,000	($5,933,000)	-41%
	Net Patient Service Revenue less provision for bad debts	**$730,456,000**	**$379,562,000**	**($350,894,000)**	**-48%**
6	Other Operating Revenue	$38,574,000	$18,266,000	($20,308,000)	-53%
7	Net Assets Released from Restrictions	$3,397,000	$1,993,000	($1,404,000)	-41%
	Total Operating Revenue	**$772,427,000**	**$399,821,000**	**($372,606,000)**	**-48%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$258,412,000	$122,840,000	($135,572,000)	-52%
2	Fringe Benefits	$63,421,000	$27,879,000	($35,542,000)	-56%
3	Physicians Fees	$52,062,000	$22,292,000	($29,770,000)	-57%
4	Supplies and Drugs	$115,390,000	$65,971,000	($49,419,000)	-43%
5	Depreciation and Amortization	$44,179,000	$19,210,000	($24,969,000)	-57%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$8,115,000	$4,421,000	($3,694,000)	-46%
8	Malpractice Insurance Cost	$8,753,000	$4,721,000	($4,032,000)	-46%
9	Other Operating Expenses	$211,691,000	$115,900,000	($95,791,000)	-45%
	Total Operating Expenses	**$762,023,000**	**$383,234,000**	**($378,789,000)**	**-50%**
	Income/(Loss) From Operations	**$10,404,000**	**$16,587,000**	**$6,183,000**	**59%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,882,000	$4,945,000	($1,937,000)	-28%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,960,000)	($421,000)	$4,539,000	-92%
	Total Non-Operating Revenue	**$1,922,000**	**$4,524,000**	**$2,602,000**	**135%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,000**	**$21,111,000**	**$8,785,000**	**71%**
	Principal Payments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 MARCH	AMOUNT DIFFERENCE	% DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$72,316,000	$49,467,000	($22,849,000)	-32%
2	Short Term Investments	$49,401,000	$30,955,000	($18,446,000)	-37%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$124,168,000	$137,830,000	$13,662,000	11%
4	Current Assets Whose Use is Limited for Current Liabilities	$5,754,000	$0	($5,754,000)	-100%
5	Due From Affiliates	$3,147,000	$6,481,000	$3,334,000	106%
6	Due From Third Party Payers	$5,513,000	$675,000	($4,838,000)	-88%
7	Inventories of Supplies	$14,316,000	$15,242,000	$926,000	6%
8	Prepaid Expenses	$8,569,000	$7,391,000	($1,178,000)	-14%
9	Other Current Assets	$13,155,000	$13,435,000	$280,000	2%
	Total Current Assets	**$296,339,000**	**$261,476,000**	**($34,863,000)**	**-12%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$71,841,414	$73,184,000	$1,342,586	2%
2	Board Designated for Capital Acquisition	$67,971,586	$72,277,000	$4,305,414	6%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$24,717,000	$0	($24,717,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$164,530,000**	**$145,461,000**	**($19,069,000)**	**-12%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$52,748,000	$58,285,000	$5,537,000	10%
7	Other Noncurrent Assets	$18,518,000	$17,556,000	($962,000)	-5%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$551,097,000	$570,246,000	$19,149,000	3%
2	Less: Accumulated Depreciation	$49,168,000	$79,463,000	$30,295,000	$1
	Property, Plant and Equipment, Net	**$501,929,000**	**$490,783,000**	**($11,146,000)**	**-2%**
3	Construction in Progress	$23,674,000	$40,973,000	$17,299,000	73%
	Total Net Fixed Assets	**$525,603,000**	**$531,756,000**	**$6,153,000**	**1%**
	Total Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 MARCH	AMOUNT DIFFERENCE	% DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$68,313,000	$63,707,000	($4,606,000)	-7%
2	Salaries, Wages and Payroll Taxes	$75,613,000	$67,903,000	($7,710,000)	-10%
3	Due To Third Party Payers	$15,903,000	$16,154,000	$251,000	2%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$7,821,000	$7,479,000	($342,000)	-4%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$11,999,000	$13,487,000	$1,488,000	12%
	Total Current Liabilities	**$179,649,000**	**$168,730,000**	**($10,919,000)**	**-6%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$256,156,000	$253,458,000	($2,698,000)	-1%
	Total Long Term Debt	**$256,156,000**	**$253,458,000**	**($2,698,000)**	**-1%**
3	Accrued Pension Liability	$314,044,000	$288,664,000	($25,380,000)	-8%
4	Other Long Term Liabilities	$79,162,000	$61,880,000	($17,282,000)	-22%
	Total Long Term Liabilities	**$649,362,000**	**$604,002,000**	**($45,360,000)**	**-7%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$123,226,000	$132,238,000	$9,012,000	7%
2	Temporarily Restricted Net Assets	$33,642,000	$36,380,000	$2,738,000	8%
3	Permanently Restricted Net Assets	$71,859,000	$73,184,000	$1,325,000	2%
	Total Net Assets	**$228,727,000**	**$241,802,000**	**$13,075,000**	**6%**
	Total Liabilities and Net Assets	**$1,057,738,000**	**$1,014,534,000**	**($43,204,000)**	**-4%**

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 OCT -MAR	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,903,594,000	$1,990,018,000	($913,576,000)	-31%
2	Less: Allowances	$1,902,814,000	$1,329,832,000	($572,982,000)	-30%
3	Less: Charity Care	$16,893,000	$14,729,000	($2,164,000)	-13%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$983,887,000**	**$645,457,000**	**($338,430,000)**	**-34%**
5	Provision for Bad Debts	$21,382,000	$16,997,000	($4,385,000)	-21%
	Net Patient Service Revenue less provision for bad debts	**$962,505,000**	**$628,460,000**	**($334,045,000)**	**-35%**
6	Other Operating Revenue	$48,990,000	$36,152,000	($12,838,000)	-26%
7	Net Assets Released from Restrictions	$7,991,000	$2,494,000	($5,497,000)	-69%
	Total Operating Revenue	**$1,019,486,000**	**$667,106,000**	**($352,380,000)**	**-35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$447,852,000	$314,233,000	($133,619,000)	-30%
2	Fringe Benefits	$94,930,000	$52,558,000	($42,372,000)	-45%
3	Physicians Fees	$33,406,000	$24,902,000	($8,504,000)	-25%
4	Supplies and Drugs	$162,109,000	$107,533,000	($54,576,000)	-34%
5	Depreciation and Amortization	$50,735,000	$30,251,000	($20,484,000)	-40%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$9,056,000	$5,047,000	($4,009,000)	-44%
8	Malpractice Insurance Cost	$12,300,000	$9,480,000	($2,820,000)	-23%
9	Other Operating Expenses	$212,471,000	$114,986,000	($97,485,000)	-46%
	Total Operating Expenses	**$1,022,859,000**	**$658,990,000**	**($363,869,000)**	**-36%**
	Income/(Loss) From Operations	**($3,373,000)**	**$8,116,000**	**$11,489,000**	**-341%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$5,917,000	$6,960,000	$1,043,000	18%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$54,901,000	($448,000)	($55,349,000)	-101%
	Total Non-Operating Revenue	**$60,818,000**	**$6,512,000**	**($54,306,000)**	**-89%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$57,445,000**	**$14,628,000**	**($42,817,000)**	**-75%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%

TRINITY HEALTH - NEW ENGLAND, INC. (FORMERLY SAINT FRANCIS CARE, INC.)

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	OCT -MAR	DIFFERENCE	DIFFERENCE
	Total Other Adjustments	$0	$0	$0	0%
	Excess/(Deficiency) of Revenue Over Expenses	$57,445,000	$14,628,000	($42,817,000)	-75%

User, OHCA

From: Roberts, Karen
Sent: Wednesday, November 22, 2017 10:01 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: CON Order Requirements Due 11/30 - Request for Extension

---

From: Martone, Kim
Sent: Wednesday, November 22, 2017 9:59 AM
To: 'MRosadin@stfranciscare.org' <MRosadin@stfranciscare.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: CON Order Requirements Due 11/30 - Request for Extension

Happy holidays Mary Lou, your extension is approved.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Subject: CON Order Requirements Due 11/30 - Request for Extension

Good afternoon Karen,

We are requesting an extension on our filing of the requirements under the Saint Francis, Johnson and Saint Mary's CONs. We expect to file on Friday, December 8, 2017. Please let us know if this is acceptable.

Thank you and Happy Thanksgiving.

Mary Lou Rosadini
Executive Associate to Vice President, Finance
Saint Francis Hospital and Medical Center

mrosadin@stfranciscare.org
W 860-714-1066

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Hartford, CT 06105

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User, OHCA

From: Roberts, Karen
Sent: Friday, December 08, 2017 11:51 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: Docket #s 32002, 31979, 32045

From: Roberts, Karen
Sent: Friday, December 8, 2017 11:49 AM
To: Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: CON Order Requirements Due 12/8

Hi Claudio – I received you voicemail this morning and it is fine to send in the bulk of the compliance filing for the three merger CONs to OHCA today and then send up the final piece (capital investments/resources) as soon as available next week. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Cotto, Carmen
Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org) <MRosadin@stfranciscare.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Schneider, Jennifer (JSchneider@stfranciscare.org) <JSchneider@stfranciscare.org>; Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org) <Claudio.Capone@TrinityHealth-NE.org>; User, OHCA <OHCA@ct.gov>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

In reference to the semi-annual documents to be filed on December 8 and future filings, please provide any related data in both PDF and Excel format, as applicable. In particular, those related to capital

commitment expenditures, cost savings and quarterly financial measures. As you might already know, Excel format makes it easier to filter and analyzed the data.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
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Executive Associate to Vice President, Finance
Saint Francis Hospital and Medical Center

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User, OHCA

From: Roberts, Karen
Sent: Friday, December 08, 2017 2:07 PM
To: Capone, Claudio
Cc: Cotto, Carmen; Martone, Kim; User, OHCA; Clarke, Ormand
Subject: CON Compliance for Docket #s 31979, 32002, 32045

Hi Claudio - I've touched base with Kim Martone, Director of Operations regarding your request for a couple of additional days for filing the entire semi-annual reporting packet for CON Docket #s 31979, 32002, 32045 and we find this acceptable. Please file your material to OHCA@ct.gov. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

-----Original Message-----
From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealthOfNE.org]
Sent: Friday, December 8, 2017 1:03 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: FW: CON Order Requirements Due 12/8

Can we send you the whole packet instead of pieces?

Sent from my iPhone

On Dec 8, 2017, at 11:48 AM, Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>> wrote:

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your Password.

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Office of Health Care Access

Connecticut Department of Public Health
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Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>) <MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>>
Cc: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>; Schneider, Jennifer (JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>) <JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio (Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>) <Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>>; User, OHCA <OHCA@ct.gov<mailto:OHCA@ct.gov>>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

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Associate Health Care Analyst
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From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
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Executive Associate to Vice President, Finance Saint Francis Hospital and Medical Center
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stfranciscare.com<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.saintfranciscare.com&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=xA-pHuONh2oLjplBmRjiQQU3cgGnjNs8UYBoGfwzluc&e=> | Facebook<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.facebook.com_SaintFrancisCT_&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=eaaYCzoAs3NzdPuq0RHvYg-p6keuRto5PH0XYHXMQHs&e=> | Twitter<https://urldefense.proofpoint.com/v2/url?u=https-3A__twitter.com_SaintFrancisCT&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=gdAZ7TJcFUh0Rea7NbHF6HFSO1fiQsro9BnnLgWXeYI&e=> | Instagram<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.instagram.com_saintfrancisct&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=rZqTOwGtsYoPaQUdgNLcrbiZeXO27iyIg6s7FKiIjEM&e=> | LinkedIn<https://urldefense.proofpoint.com/v2/url?u=http-3A__bit.ly_2g16PSv&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=Z8iYz_mkpxwpKN985Dv8qjDzqyN5pkp-4XfS_k2bisY&e=>

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User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Sent: Friday, December 08, 2017 2:30 PM
To: Roberts, Karen
Cc: Cotto, Carmen; Martone, Kim; User, OHCA; Clarke, Ormand
Subject: RE: CON Compliance for Docket #s 31979, 32002, 32045

Karen...Thank you for the quick response. We will file our complete packets no later than Tuesday morning.

Regards,

Claudio A. Capone, FACHE
Regional VP of Strategic Planning
Trinity Health Of New England
Claudio.Capone@TrinityHealthOfNE.org
W 860-714-6165
C 860-276-7975
1000 Asylum Avenue, 2109A
Hartford, CT 06105
trinityhealth-ne.org | facebook | twitter | instagram

-----Original Message-----
From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Friday, December 8, 2017 2:07 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; User, OHCA <OHCA@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: [EXTERNAL] CON Compliance for Docket #s 31979, 32002, 32045

Warning: This email originated from the Internet!

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Hi Claudio - I've touched base with Kim Martone, Director of Operations regarding your request for a couple of additional days for filing the entire semi-annual reporting packet for CON Docket #s 31979, 32002, 32045 and we find this acceptable. Please file your material to OHCA@ct.gov. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

-----Original Message-----

From: Capone, Claudio [mailto:Claudio.Capone@TrinityHealthOfNE.org]
Sent: Friday, December 8, 2017 1:03 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: FW: CON Order Requirements Due 12/8

Can we send you the whole packet instead of pieces?

Sent from my iPhone

On Dec 8, 2017, at 11:48 AM, Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>> wrote:

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your Password.

_____

Hi Claudio - I received you voicemail this morning and it is fine to send in the bulk of the compliance filing for the three merger CONs to OHCA today and then send up the final piece (capital investments/resources) as soon as available next week. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov<mailto:karen.roberts@ct.gov>

<image001.jpg><image005.jpg>

From: Cotto, Carmen
Sent: Monday, December 4, 2017 3:41 PM
To: Rosadini, Mary Lou (MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>)
<MRosadin@stfranciscare.org<mailto:MRosadin@stfranciscare.org>>
Cc: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>; Schneider, Jennifer
(JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>)
<JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio
(Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>)
<Claudio.Capone@TrinityHealth-NE.org<mailto:Claudio.Capone@TrinityHealth-NE.org>>; User, OHCA
<OHCA@ct.gov<mailto:OHCA@ct.gov>>
Subject: CON Order Requirements Due 12/8

Good afternoon Mary Lou,

In reference to the semi-annual documents to be filed on December 8 and future filings, please provide any related data in both PDF and Excel format, as applicable. In particular, those related to capital commitment expenditures, cost savings and quarterly financial measures. As you might already know, Excel format makes it easier to filter and analyzed the data.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov<mailto:carmen.cotto@ct.gov>

www.ct.gov/dph<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.ct.gov_dph&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=GHKw6oAuDS7C_eA86IpGSs-Hl_J8v9doeKYU9MwH-MQ&e=>

From: Rosadini, Mary Lou [mailto:MRosadin@stfranciscare.org]
Sent: Tuesday, November 21, 2017 2:41 PM
To: Roberts, Karen <Karen.Roberts@ct.gov<mailto:Karen.Roberts@ct.gov>>
Cc: Schneider, Jennifer <JSchneider@stfranciscare.org<mailto:JSchneider@stfranciscare.org>>; Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org<mailto:Claudio.Capone@TrinityHealthOfNE.org>>
Subject: CON Order Requirements Due 11/30 - Request for Extension

Good afternoon Karen,

We are requesting an extension on our filing of the requirements under the Saint Francis, Johnson and Saint Mary's CONs. We expect to file on Friday, December 8, 2017. Please let us know if this is acceptable.

Thank you and Happy Thanksgiving.

Mary Lou Rosadini
Executive Associate to Vice President, Finance Saint Francis Hospital and Medical Center
mrosadin@stfranciscare.org<mailto:mrosadin@stfranciscare.org>
W 860-714-1066
114 Woodland Street
Hartford, CT 06105
stfranciscare.com<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.saintfranciscare.com&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=xA-pHuONh2oLjplBmRjiQQU3cgGnjNs8UYBoGfwzluc&e=> | Facebook<https://urldefense.proofpoint.com/v2/url?u=https-3A__www.facebook.com_SaintFrancisCT_&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-IM4J7ErS7kFgPjW_C4gxYg9uZQxpjezUwqt18qFw&s=eaaYCzoAs3NzdPuq0RHvYg-p6keuRto5PH0XYHXMQHs&e=> | Twitter<https://urldefense.proofpoint.com/v2/url?u=https-3A__twitter.com_SaintFrancisCT&d=DwMFAg&c=ajsCdbKXBnPSZ1CsuYmR1LYTCaOGXxYGeIEIboVILfw&r=ReYNGn6ZVauzYJKyy3QbfWlHDR-ixBKLOM_mGduZRci09L9Rv8pGIoJunHwDW13Y&m=86-

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User, OHCA

From: Cotto, Carmen
Sent: Thursday, December 14, 2017 1:59 PM
To: Roberts, Karen; User, OHCA
Subject: FW: TH Of NE Combined Filing for CON Conditions
Attachments: TH - NE 12.08.2017 COMBINED CON Conditions Filing-signed.pdf; Attachment C Johnson cashflow.xls; Attachment C Report 100 150.xlsx; Attachment B CMAED.docx; Attachment D CON Stats for JMH.xlsx; Attachment A Detail of 6 month savings.xlsx; Attachment B SFH_SFCARE cashflow.xls; Attachment B SAFNS - Reports 100 150 9 30 17.xlsx; Attachment A Detail of 6 month savings 9-30-2017.xlsx; Saint Francis Stipulation 9 Final Attachments.xlsx; CON stats Sept 2017.xlsx; Attachment 1 - Saint Mary's - FA OCHA Info for Apr17-Sep17.xlsx; Report 100_150_300_350_Sept 2017.xlsx

FYI-Claudio has to use his personal email to send the documents.

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: Trinity Health – New England Transfer of Ownership CON Conditions for:

- Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-31979-CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England
- Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

Dear Mrs. Roberts,

In accordance with Trinity Health Of New England's approved CONs for the transfers of ownership of Saint Francis Care, Inc,. and Saint Mary's Health Systems, Inc. to Trinity Health Corporation and Trinity Health Of New England and for the transfer of ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc. (NKA Trinity Health Of New England), attached are the responses to the conditions set forth in each of the CON decisions.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development
Enc.

Docket Number: 15-32045-CON
Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Roberts:

In accordance with Items 6, 7, 8, 9 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

7. ***Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:***
    - ***A. A list of the of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and***
    - ***B. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and***
    - ***C. The funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.***

   The reports shall be signed by the Hospital's or TH-NE's Chief Financial Officer.

   See Excel Attachment 1.

8. ***For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:***

   a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

   1. the major cost savings achieved for each expense category for the semi-annual period; and

   In March of 2017, Saint Mary's switched to Trinity Health's GPO. After 6 months, estimated total savings is about $1 million.

2. the effect of these cost savings on the clinical quality of care.

There has been no impact to clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/300 (statement of operations), or successor reports.

See Attachment 2.

9. ***For three (3) years following the Closing Date, TH-NE shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for TH-NE. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016.***

   See Attachment 3 for financial indicators.

10. ***TH-NE shall ensure that the Hospital maintains and adheres to the Hospital's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.***

    In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

ATTACHMENT 1
see excel file that accompanied
this package

ATTACHMENT 2

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$20,572,000	$12,027,000	($8,545,000)	-42%
2	Short Term Investments	$23,000	$0	($23,000)	-100%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$26,298,000	$30,481,000	$4,183,000	16%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,889,000	$3,981,000	$92,000	2%
8	Prepaid Expenses	$2,930,000	$1,184,000	($1,746,000)	-60%
9	Other Current Assets	$3,114,000	$6,416,000	$3,302,000	106%
	Total Current Assets	**$56,826,000**	**$54,089,000**	**($2,737,000)**	**-5%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$15,480,000	$16,334,000	$854,000	6%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$6,000	$6,000	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$15,486,000**	**$16,340,000**	**$854,000**	**6%**
5	Interest in Net Assets of Foundation	$5,549,000	$6,120,000	$571,000	10%
6	Long Term Investments	$10,973,000	$13,507,000	$2,534,000	23%
7	Other Noncurrent Assets	$25,740,000	$20,465,000	($5,275,000)	-20%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$91,358,000	$144,239,000	$52,881,000	58%
2	Less: Accumulated Depreciation	$2,656,000	$18,974,000	$16,318,000	614%
	Property, Plant and Equipment, Net	**$88,702,000**	**$125,265,000**	**$36,563,000**	**41%**
3	Construction in Progress	$7,780,000	$2,115,000	($5,665,000)	-73%
	Total Net Fixed Assets	**$96,482,000**	**$127,380,000**	**$30,898,000**	**32%**
	Total Assets	**$211,056,000**	**$237,901,000**	**$26,845,000**	**13%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$15,420,000	$14,094,000	($1,326,000)	-9%
2	Salaries, Wages and Payroll Taxes	$5,045,000	$6,977,000	$1,932,000	38%
3	Due To Third Party Payers	$1,262,000	$673,000	($589,000)	-47%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$89,000	$609,000	$520,000	584%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$15,913,000	$23,435,000	$7,522,000	47%
	Total Current Liabilities	**$37,729,000**	**$45,788,000**	**$8,059,000**	**21%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$0	$24,494,000	$24,494,000	0%
	Total Long Term Debt	**$0**	**$24,494,000**	**$24,494,000**	**0%**
3	Accrued Pension Liability	$83,306,000	$73,482,000	($9,824,000)	-12%
4	Other Long Term Liabilities	$9,341,000	$18,252,000	$8,911,000	95%
	Total Long Term Liabilities	**$92,647,000**	**$116,228,000**	**$23,581,000**	**25%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$62,162,000	$56,186,000	($5,976,000)	-10%
2	Temporarily Restricted Net Assets	$1,970,000	$2,315,000	$345,000	18%
3	Permanently Restricted Net Assets	$16,548,000	$17,384,000	$836,000	5%
	Total Net Assets	**$80,680,000**	**$75,885,000**	**($4,795,000)**	**-6%**
	Total Liabilities and Net Assets	**$211,056,000**	**$237,901,000**	**$26,845,000**	**13%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$817,116,000	$879,852,000	$62,736,000	8%
2	Less: Allowances	$533,069,000	$596,674,000	$63,605,000	12%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$277,097,000**	**$274,164,000**	**($2,933,000)**	**-1%**
5	Provision for Bad Debts	$6,835,000	$6,668,000	($167,000)	-2%
	Net Patient Service Revenue less provision for bad debts	**$270,262,000**	**$267,496,000**	**($2,766,000)**	**-1%**
6	Other Operating Revenue	$12,538,000	$11,803,000	($735,000)	-6%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$282,800,000**	**$279,299,000**	**($3,501,000)**	**-1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$92,109,000	$98,418,000	$6,309,000	7%
2	Fringe Benefits	$27,925,000	$16,882,000	($11,043,000)	-40%
3	Physicians Fees	$17,827,000	$14,767,000	($3,060,000)	-17%
4	Supplies and Drugs	$44,872,000	$46,827,000	$1,955,000	4%
5	Depreciation and Amortization	$12,141,000	$16,327,000	$4,186,000	34%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$197,000	$246,000	$49,000	25%
8	Malpractice Insurance Cost	$5,079,000	$3,075,000	($2,004,000)	-39%
9	Other Operating Expenses	$52,564,000	$58,433,000	$5,869,000	11%
	Total Operating Expenses	**$252,714,000**	**$254,975,000**	**$2,261,000**	**1%**
	Income/(Loss) From Operations	**$30,086,000**	**$24,324,000**	**($5,762,000)**	**-19%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$915,000	$1,123,000	$208,000	23%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$137,000	$41,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,052,000**	**$1,164,000**	**$112,000**	**11%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$31,138,000**	**$25,488,000**	**($5,650,000)**	**-18%**

SAINT MARY`S HOSPITAL (Hospital Only)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$31,138,000**	**$25,488,000**	**($5,650,000)**	**-18%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$22,818,000	$14,871,000	($7,947,000)	-35%
2	Short Term Investments	$23,000	$0	($23,000)	-100%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$30,634,000	$35,927,000	$5,293,000	17%
4	Current Assets Whose Use is Limited for Current Liabilities	$3,418,000	$0	($3,418,000)	-100%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,889,000	$3,981,000	$92,000	2%
8	Prepaid Expenses	$3,515,000	$1,450,000	($2,065,000)	-59%
9	Other Current Assets	$3,192,000	$6,429,000	$3,237,000	101%
	Total Current Assets	**$67,489,000**	**$62,658,000**	**($4,831,000)**	**-7%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$15,480,000	$16,334,000	$854,000	6%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$19,537,000	$6,000	($19,531,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$35,017,000**	**$16,340,000**	**($18,677,000)**	**-53%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$15,428,000	$18,940,000	$3,512,000	23%
7	Other Noncurrent Assets	$6,263,000	$19,887,000	$13,624,000	218%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$95,973,000	$149,155,000	$53,182,000	55%
2	Less: Accumulated Depreciation	$2,835,000	$20,269,000	$17,434,000	615%
	Property, Plant and Equipment, Net	**$93,138,000**	**$128,886,000**	**$35,748,000**	**38%**
3	Construction in Progress	$7,873,000	$2,334,000	($5,539,000)	-70%
	Total Net Fixed Assets	**$101,011,000**	**$131,220,000**	**$30,209,000**	**30%**
	Total Assets	**$225,208,000**	**$249,045,000**	**$23,837,000**	**11%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

30-Sep-17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$16,465,000	$15,256,000	($1,209,000)	-7%
2	Salaries, Wages and Payroll Taxes	$8,160,000	$9,774,000	$1,614,000	20%
3	Due To Third Party Payers	$1,262,000	$673,000	($589,000)	-47%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$337,000	$771,000	$434,000	129%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$13,842,000	$25,202,000	$11,360,000	82%
	Total Current Liabilities	**$40,066,000**	**$51,676,000**	**$11,610,000**	**29%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$586,000	$24,946,000	$24,360,000	4157%
	Total Long Term Debt	**$586,000**	**$24,946,000**	**$24,360,000**	**4157%**
3	Accrued Pension Liability	$83,306,000	$73,482,000	($9,824,000)	-12%
4	Other Long Term Liabilities	$21,395,000	$19,082,000	($2,313,000)	-11%
	Total Long Term Liabilities	**$105,287,000**	**$117,510,000**	**$12,223,000**	**12%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,588,000	$2,510,000	($78,000)	-3%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$58,749,000	$57,550,000	($1,199,000)	-2%
2	Temporarily Restricted Net Assets	$1,970,000	$2,414,000	$444,000	23%
3	Permanently Restricted Net Assets	$16,548,000	$17,385,000	$837,000	5%
	Total Net Assets	**$77,267,000**	**$77,349,000**	**$82,000**	**0%**
	Total Liabilities and Net Assets	**$225,208,000**	**$249,045,000**	**$23,837,000**	**11%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$916,268,000	$978,048,000	$61,780,000	7%
2	Less: Allowances	$593,367,000	$654,455,000	$61,088,000	10%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$315,951,000**	**$314,579,000**	**($1,372,000)**	**0%**
5	Provision for Bad Debts	$8,969,000	$9,041,000	$72,000	1%
	Net Patient Service Revenue less provision for bad debts	**$306,982,000**	**$305,538,000**	**($1,444,000)**	**0%**
6	Other Operating Revenue	$10,321,000	$13,807,000	$3,486,000	34%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$317,303,000**	**$319,345,000**	**$2,042,000**	**1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$132,586,000	$141,975,000	$9,389,000	7%
2	Fringe Benefits	$33,001,000	$22,785,000	($10,216,000)	-31%
3	Physicians Fees	$18,159,000	$15,701,000	($2,458,000)	-14%
4	Supplies and Drugs	$46,930,000	$48,790,000	$1,860,000	4%
5	Depreciation and Amortization	$12,879,000	$17,455,000	$4,576,000	36%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$218,000	$275,000	$57,000	26%
8	Malpractice Insurance Cost	$2,289,000	$4,415,000	$2,126,000	93%
9	Other Operating Expenses	$62,569,000	$69,004,000	$6,435,000	10%
	Total Operating Expenses	**$308,631,000**	**$320,400,000**	**$11,769,000**	**4%**
	Income/(Loss) From Operations	**$8,672,000**	**($1,055,000)**	**($9,727,000)**	**-112%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,361,000	$1,636,000	$275,000	20%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$138,000	$42,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,499,000**	**$1,678,000**	**$179,000**	**12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

ATTACHMENT 3

Saint Mary's Hospital (hospital only)	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	2.6%	10.9%	8.7%	10.6%
Non-Operating Margin	0.6%	0.1%	0.4%	0.4%
Total Margin	3.1%	11.0%	9.1%	11.0%
Bad Debt as % of Gross Revenue	1.6%	0.1%	0.8%	0.8%
B. Liquidity				
Current Ratio	1.48	1.80	1.48	1.80
Days Cash on Hand	17	32	17	32
Days in Net Accounts Receivable	42	36	42	36
Average Payment Period	46	56	46	56
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.33	0.00	0.33	0.00
Long-term Debt to Capitalization	0.25	0.00	0.25	0.00
Unrestricted Cash to Debt	0.48	231.74	0.48	231.74
Times Interest Earned Ratio	9.9	1177.1	104.71	159.03
Debt Service Coverage Ratio	31.4	138.1	53.04	125.89
Equity Financing Ratio	3.14	2.62	3.14	2.62
D. Additional Statistics				
Income from Operations	$ 588	$ 2,523	$ 24,324	$ 30,086
Revenue Over/(Under) Expense	$ 721	$ 2,537	$ 25,488	$ 31,138
EBITDA	$ 2,040	$ 3,867	$ 40,897	$ 42,424
Patient Cash Collected	$ 19,564	$ 20,601	$ 258,671	$ 259,506
Cash and Cash Equivalents	$ 12,027	$ 20,572	$ 12,027	$ 20,572
Net Working Capital	$ 8,303	$ 19,097	$ 8,303	$ 19,097
Unrestricted Assets	$ 56,185	$ 62,163	$ 56,185	$ 62,163
Credit Ratings (S&P, FITCH and Moody's)				

Saint Mary's Health System	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	-5.6%	1.2%	-0.3%	2.7%
Non-Operating Margin	0.7%	0.2%	0.5%	0.5%
Total Margin	-4.8%	1.4%	0.2%	3.2%
Bad Debt as % of Gross Revenue	1.7%	0.5%	0.9%	1.0%
B. Liquidity				
Current Ratio	1.58	2.07	1.58	2.07
Days Cash on Hand	17	28	17	28
Days in Net Accounts Receivable	43	37	43	37
Average Payment Period	44	51	44	51
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.32	0.01	0.32	0.01
Long-term Debt to Capitalization	0.24	0.01	0.24	0.01
Unrestricted Cash to Debt	0.58	24.73	0.58	24.73
Times Interest Earned Ratio	-14.2	76.9	3.27	47.59
Debt Service Coverage Ratio	1.0	62.7	21.63	64.60
Equity Financing Ratio	3.12	2.82	3.12	2.82
D. Additional Statistics				
Income from Operations	$ (1,460)	$ 311	$ (1,055)	$ 8,672
Revenue Over/(Under) Expense	$ (1,265)	$ 373	$ 623	$ 10,171
EBITDA	$ 64	$ 1,755	$ 16,674	$ 21,769
Patient Cash Collected	$ 22,724	$ 23,618	$ 296,730	$ 296,240
Cash and Cash Equivalents	$ 14,871	$ 22,818	$ 14,871	$ 22,818
Net Working Capital	$ 10,981	$ 27,421	$ 10,981	$ 27,421
Unrestricted Assets	$ 60,060	$ 61,337	$ 60,060	$ 61,337
Credit Ratings (S&P, FITCH and Moody's)				

Docket Number: 15-31979-CON
Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation and Trinity Health - New England

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation
Response to Item 9 of the Settlement and Order dated 8/1/2015
Annual Report for the Capital Investment Plan due 11/30/2017

Question 1

Provide a five-year post-closing capital investment plan detailing the proposed allocation of the $275 million capital investment commitment. The submitted plan shall account for the full $275 million commitment as stated in the proposal and include the following information:

a. A list of planned capital expenditures with detailed descriptions and associated estimated costs, and

Please refer to **Attachment 2** for FY 2017 actual capital expenditures for the twelve month period ended September 30, 2017.

Attachment 3 includes the final approved capital budget (see column C) for Trinity Health Of New England Corporation, Inc. (TH Of NE) which has been approved by Trinity Health's governing body and presented to TH Of NE's finance committee. The FY 2018 budget is for the period 7/1/2017-6/30/2018.

Attachment 3 has also been updated to reflect preliminary capital budget for FYs 2019 and 2020. TH Of NE, including Saint Francis Hospital and Medical Center, have recently completed the most recent strategic plan and will be embarking on a Master Facilities Plan in CY 2018 which will further define capital priorities over the next three to five years. In addition, as strategic projects are identified, there is a process in place to facilitate the receipt of additional capital funding from Trinity Health for these priorities. One example of a strategic priority currently under review is the Ambulatory Surgery Center (ASC) in Hartford. The ASC has been included on the attached preliminary capital budget.

b. A timeframe for the rollout of the capital projects, including estimated beginning, ending and start-up/operation dates.

See **Attachment 4** for the FY 2018 individual capital projects greater than $100,000 that have been approved to proceed at Saint Francis. The remaining dollars relating to the capital budget will be allocated based on current priorities and any critical needs that arise. These amounts are summarized by category on **Attachment 3**.

As the strategic plan is finalized and the more significant capital investments are identified, TH Of NE will provide OHCA with an update for this stipulation. TH Of NE continues to believe this approach will ensure the greatest accuracy as well as meet the intent of this stipulation.

Attachment 2
Capital Expenditure Summary
FY17 Actuals - 10/1/2016-9/30/2017
Expenditures > $100,000

	Actuals FY17
Expansion/renovations of clinical facilities	
8-2 RENOVATION	1,010,293
New compounding pharmacy for Enfield Infusion center (Johnson)	561,658
Cath Lab Renovation	464,916
Major Building Renovation	304,442
Digital Rad/Fluoro Suite Renovation	183,642
Fresh tissue lab renovation	142,340
All Other	77,620
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	
Wireless telemetry monitoring system and other patient care services equipment (Auxiliary)	1,112,037
Stryker Power Equipment	962,422
Replacment of the treatment planning system; Pinncle and transition to Raytstation.	464,125
Stryker Sonopet (Qty 2) Spine and OR	301,625
OSI Spine Table	103,776
All Other	131,464
Information Technology	
IT Infrastructure to support CT hospitals	7,815,836
Hardware General, IT Refresh	1,170,494
Infrastructure Movement and Replacmement of Data Center	661,965
EMC archive to migrate data from Caremedic	197,873
EPIC-PHASE 2 (PHASE 1 CIP1253)	172,286
Software-General OB Server	172,125
All Other	190,749
Investment in facilities, medical and non-medical equipment and technology	
Replace portable X-Ray Units(2)/Replace X-Ray Rad Room	1,236,315
Bed and patient recliner replacement	1,193,940
Energy Upgrade-SFHMC, RHHCT, & JMMC	617,382
Replace Dearatoron boiler system	508,753
North Campus Roof Replacement	348,793
Replace Nurse Call Center	334,675
Window Replacement Program	243,075
Generator Emergency - Replace the 400KW Building 1 Generator	233,746
Emergency Room Stretchers and Ultrasounds	227,617
4 Heat Exchangers-Cancer Center	222,365
CardioQuip Heater Cooler	211,177
SPY Intraoperative Laser Angio	175,000
Natus Vision EEG system	151,067
HVAC - Air-conditioner - HVAC - AHU - Replace S-6 In Lower Penthouse in B-2	140,433
REPLACE COLLINS GARAGE RUSTED CONDUITS/WIRING	133,629
Philips EPIQ 7 Echo Machine	131,043
FACILITIES GEN. - RENOV-ELECT.WHOLESALERS FACILITY FOR PARKING	124,006
Medivator Washers	115,301
Purchase Cryo Console	100,000
All Other (n=95)	703,722
Physician acquisitions/ambulatory network development	
SFMG Vernon Suite 200-201	459,964

Attachment 2
Capital Expenditure Summary
FY17 Actuals - 10/1/2016-9/30/2017
Expenditures > $100,000

	Actuals FY17
Medical Office Building Renovations	392,486
ASC Project (Planning, Design and Construction)	110,542
All Other	66,347
Reallocation to Johnson Memorial - part of strategic growth of RHM	
PeopleSoft Implementation	416,167
Kronos Implementation	412,756
All Other	15,739
Saint Mary's Epic Implementation	
Epic Implementation	**21,433,313**
Capital leases associated with Epic and other	
Capital leases associated with Epic and other	**1,298,154**
Total	**47,959,194**
Johnson local capital expenditures (see Johnson Filing)	$ 2,259,103
Saint Mary's local capital expenditures (see Saint Mary's Filing)	26,210,322
Total Capital Expenditures THOFNE CT Hospitals	$ 76,428,619.18

Attachment 3

Preliminary Capital Investment Plan for Trinity Health Of New England (f/k/a Saint Francis *Care* , Inc.)

Dollars in Thousands

	<Prior Version> (a)	<Actuals> <Prior Version>	<Actuals> <New> (b)	|----------(c)(d) ----------|			
	Five Year Total	FY 2016 Expenditures (10/1/2015-9/30/2016)	FY2017 Expenditures (10/1/16- 9/30/17)	FY 2018 Budget (7/1/2017-6/30/2018)	FY 2019 Budget (7/1/2018-6/30/2019)	FY 2020 Budget (7/1/2019-6/30/2020)	Estimated Post-Close Five Year Capital Spend
Preliminary capital expenditures summary							
Investment in facilities, medical and non-medical equipment and technology	$ 184,000	$ 21,428	$ 7,152	$ 2,738	$ 15,000	$ 15,000	$ 61,318
Capital leases associated with Epic and other	4,500	1,028	1,298	-	-	-	2,326
Facility & program improvements for various service lines (e.g., CJRI, Rehab)	5,000	3,104	3,075	100	2,000	2,000	10,279
Expansion/renovations of clinical facilities	10,000	-	2,183		10,000	5,000	17,183
Physician acquisitions/ambulatory network development	23,500	-	1,029	575	1,100	1,100	3,804
Information Technology	-	3,926	10,381	9,253	9,000	9,000	41,559
Unspecified; to be allocated based on organizional priorities each year	48,000	20,015	-	7,908	10,000	15,000	52,923
Adjustments to preliminary capital expenditure summary:							
Reallocation to Johnson Memorial - part of strategic growth of RHM		1,496	3,666	4,187	2,639	645	12,633
Reallocation to Saint Mary's-part of strategic growth of RHM [(e)]		-	21,282	9,133	12,500	12,500	55,415
Saint Mary's Epic Implementation		-	26,362	-	-	-	26,362
Hartford Ambulatory Surgery Center			-	4,333	5,981	1,596	11,910
Total estimated annual capital expenditures	**$ 275,000**	**$ 50,997**	**$ 76,428**	**$ 38,226**	**$ 68,220**	**$ 61,841**	**$ 295,712**

(a) Preliminary plan for capital commitment as noted on page 635 of CON.

(b) Capital expenditures 10/1/2016-9/30/2017 see detail at Attachment 2

(C) Approved Trinity Health Of New England FY18 routine capital budget for Saint Francis and Johnson is $11.3M and $0.873M, respectively. This amount is exclusive of $15.7M earmarked for TH Of NE IT projects, of which $9.3 is targeted for St. Francis. In addition, subject to final approval, an additional $11.9M (in total) has been earmarked for an Ambulatory Surgery Center in Hartford.

(d) Amounts continue to be preliminary based on evolving RHM strategy and expected investment necessary for Saint Francis facilities and equipment, etc. The Strategic plan was recently completed and the Master Facilities Plan has recently been approved to begin for TH OF NE.

(e) Saint Mary's 5 year commitment is through 2021 based on timing of affiliation.

Note: $20,015 in FY 2016 was investment in Johnson Memorial Hospital which closed on 1/1/2016

Attachment 4
Capital Expenditure Summary
FY18 Budget - 10/1/2017-9/30/2018
Currently Approved Expenditures > $100,000

	Approved FY18 Budget
Expansion/renovations of clinical facilities	
Psychiatry Renovation	100,000
Information Technology	
3 Par Replacement non EPIC epic	3,500,000
Ciena Fiber Swtitches	1,000,000
Epic Ambulatory Licensing Gap	953,100
St Francis wireless project (completion) pull cables and old AP's	500,000
Workday - Hartford	500,000
Replace EOL Rubbermaid Carts and Buyout of Leased Carts	425,000
3 Par expansion EPIC storage	300,000
Phones Voice Gateways SFH	300,000
Replace HP blades x 16	275,000
ExtaHop network/systems monitoring	270,000
Data Domain 7200 expansion	200,000
Epic Biometrics Refresh	196,367
Fuji Synpase Extension for JMMC Echos	154,000
JMMC Email migration to SFH	120,000
Kronos 8.0 Upgrade	108,000
Auxilio	105,350
SIP Trunking Border Element controllers etc. Wallingford/SFH	100,000
All Other	246,000
Investment in facilities, medical and non-medical equipment and technology	
Renovation - Minor < $2M, 6-2 Renovations	1,800,000
OR lights rooms 1-6	324,087
Microscope for Spine OR	253,318
OSI table	102,508
All Other (n=22)	258,766
Physician acquisitions/ambulatory network development	
MOB Renovations - Minor	500,000
All Other	75,000
Unspecified; to be allocated based on organizional priorities each year	
Not Yet Allocated	7,907,504
Hartford Ambulatory Surgery Center	
Estimated FY18 Capital Expenditures	4,333,000
Total for Saint Francis (excludes SMH and Johnson on Attachment 3)	**24,907,000**

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

Re: Docket Number: 15-31979 CON Transfer of Ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated August 1, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket No. 15-31979-CON- Transfer of ownership of Saint Francis Care, Inc. to Trinity Health Corporation

Response to Items #10 and #11 of the Settlement and Order dated 8/1/2015 for the Six Month Period Ended September 30, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both the Hospital and its immediate parent (SFC or its successor legal entity) for purposes of this Order, semi-annual periods are October 1 - March 31 and April l - September 30. The required information is due no later than two (2) months after the end of each semi-annal period. Due dates are May 31 and November 30, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM): Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The information shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since October 1, 2015, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Trinity Health to identify and implement changes to realize cost saving opportunities. As previously reported, a significant benefit with annual ongoing savings for Saint Francis was the defeasance of Saint Francis' long term debt of approximately $246 million with proceeds from an intercompany loan. In addition, the Series F Fixed Pay SWAP was novated to Trinity Health on October 1, 2015. The result of this SWAP was an improvement in Saint Francis' net assets of $44 million. Furthermore, the transfer of this SWAP removes the financial risks associated with the change in interest rates and the impact on Saint Francis net assets. For example, in FY 2015, Saint Francis recorded a $14.8 million non-operating loss related to this interest rate SWAP. Interest rate SWAP loss for FY 17 was $887,000. Additional interest expense savings for the six months ended September 30, 2017 was approximately $430,000 as a result of favorable interest rates.

Another significant change was the inclusion of Saint Francis into the Trinity Health insurance program. This created an overall initial decrease in annual premiums of approximately $1.3 million exclusive of one time tail coverage costs incurred as part of the transaction. Effective 7/1/2017, Saint Francis received additional annual premium reductions and the impact of this reduction was $4.4 million for Saint Francis Hospital and Medical Center. The savings for the six month period ended September 30, 2017 was approximately $1.1 million favorable compared to the first six months of the fiscal year.

Lastly, leveraging the Trinity Health actuarial expertise whose approach is to more closely align mortality assumptions with plan participant demographics in the Trinity Health pension plans,

Saint Francis' projected benefit obligation was further evaluated. As a result, Saint Francis recognized an annual benefit in pension expense of $4.2 million for the twelve month period ended September 30, 2016. For the period from April 1, 2017 through September 30, 2017, Saint Francis had additional favorability in pension expense of $3.1 million. Furthermore, Trinity and Saint Francis have developed a plan to continue to adequately fund the Saint Francis defined benefit plan consistent with the Trinity Health funding policy. For the period 10/1/2016-9/30/2017, Saint Francis made contributions to the pension plan of $27.9 million. Based on the current obligations under the plan and current funding level, Saint Francis will make contributions of $32.9 million to the plan during the period 7/1/2017-6/30/2018. Historically, Saint Francis was only able to contribute approximately $9 million to the plan annually.

In January 2017, the employees of Saint Francis were brought onto to Trinity Health benefit programs which provided several enhancements to their benefits. The most significant change is that colleagues working more than twenty hours per week are participating in a defined contribution retirement program which provides a base core contribution of 3% for everyone and a matching contribution for the first 6% of a colleague's contribution. This change resulted in over $700,000 additional contributions made to employee's plans. The new health insurance program provides comprehensive coverage at a lower average employee contribution compared to what had previously been provided.

Saint Francis continues with the transition to the Trinity Health Group Purchasing Organization, HPG. During the period April 1, 2017 to September 30, 2017, this effort has resulted in additional supply chain savings of approximately $760,000. Most of the current saving was achieved by reducing the cost on existing goods through the implementation of the Trinity Health National Agreements. Supply Chain integration activity will continue in FY17 and FY18. In addition, as we shift to SFHMC maintenance contracts to TH master agreements with the respective vendors, SFHMC has realized savings of $400,000 associated with leveraging Trinity Health pricing for these agreements.

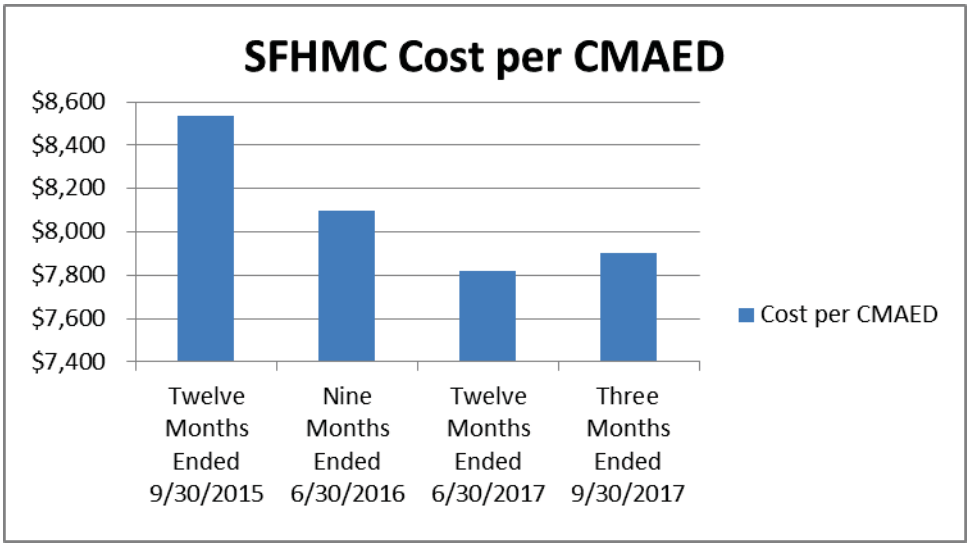
Trinity Health Of New England, Inc. (TH Of NE, formerly known as Saint Francis *Care*, Inc.), on behalf of its member hospitals including Saint Francis Hospital and Medical Center, Johnson Memorial Hospital and Saint Mary's Hospital, is currently working with Trinity Health on ensuring these hospitals continue to deliver high quality care and remain low cost providers within the community. TH-NE and Trinity Health have engaged external consultants to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.3 million benefit to the Connecticut hospitals within TH Of NE during the period 4/1/2017-9/30/2017.

Additional regionalization and alignment strategies have decreased costs in various areas including legal and external audit. Prior to 10/1/2015, Saint Francis annual audit fees were approximately $600,000. SFHMC audit fee is part of Trinity Health's audit fees and no additional expense is directly charged to the organization. Furthermore, access to legal services

at Trinity Health system office has resulted in a decrease in annual external legal fees of approximately $1.4 million.

Overall, SFHMC has seen significant decrease in costs per case mix adjusted equivalent discharge since the affiliation with Trinity Health and the establishment of the region.

Table 1: Costs per Case Mix Adjusted Equivalent Discharge



Except where otherwise noted, these cost savings will continue to be realized in future years. Furthermore, we continue to identify cost saving opportunities with vendors and will report those cost savings when realized in future reporting periods. See **Attachment A** for expense savings by category.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings. Saint Francis continues to have a strong census as well as being recognized for its clinical excellence. For example, in November 2017, Saint Francis Hospital and Medical Center has again received an "A" rating Hospital Safety Score from The Leapfrog Group, a national hospital quality watchdog organization. Saint Francis has received an "A" rating eight times since the survey's inception in 2012 and is one of only five Connecticut hospitals to receive an "A" rating this year.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent (SFC or its successor legal entity, SFCRHM). The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment B.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The

required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment C** for Financial Indicators.

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$3,100
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$760
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$430
H.	Malpractice Insurance Cost	$1,100
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$400
	Total savings 10/1-3/31	$5,790

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	SEPTEMBER	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$17,282,000	$16,067,000	($1,215,000)	-7%
2	Short Term Investments	$37,626,000	$44,486,000	$6,860,000	18%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$64,589,000	$64,796,000	$207,000	0%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$47,486,000	$90,696,000	$43,210,000	91%
6	Due From Third Party Payers	$5,513,000	$6,245,000	$732,000	13%
7	Inventories of Supplies	$8,913,000	$8,663,000	($250,000)	-3%
8	Prepaid Expenses	$3,861,000	$2,400,000	($1,461,000)	-38%
9	Other Current Assets	$3,498,000	$17,525,000	$14,027,000	401%
	Total Current Assets	**$188,768,000**	**$250,878,000**	**$62,110,000**	**33%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$98,242,000	$107,707,000	$9,465,000	10%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$2,118,000	$1,783,000	($335,000)	-16%
	Total Noncurrent Assets Whose Use is Limited:	**$100,360,000**	**$109,490,000**	**$9,130,000**	**9%**
5	Interest in Net Assets of Foundation	$13,266,000	$10,197,000	($3,069,000)	-23%
6	Long Term Investments	$48,717,000	$49,364,000	$647,000	1%
7	Other Noncurrent Assets	$7,050,000	$7,050,000	$0	0%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$418,811,000	$446,444,000	$27,633,000	7%
2	Less: Accumulated Depreciation	$43,734,000	$82,940,000	$39,206,000	90%
	Property, Plant and Equipment, Net	**$375,077,000**	**$363,504,000**	**($11,573,000)**	**-3%**
3	Construction in Progress	$14,905,000	$12,103,000	($2,802,000)	-19%
	Total Net Fixed Assets	**$389,982,000**	**$375,607,000**	**($14,375,000)**	**-4%**
	Total Assets	**$748,143,000**	**$802,586,000**	**$54,443,000**	**7%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,163,000	$29,121,000	($5,042,000)	-15%
2	Salaries, Wages and Payroll Taxes	$38,144,000	$31,072,000	($7,072,000)	-19%

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	SEPTEMBER	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$8,953,000	$8,727,000	($226,000)	-3%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$6,925,000	$5,761,000	($1,164,000)	-17%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$9,045,000	$13,365,000	$4,320,000	48%
	Total Current Liabilities	**$97,230,000**	**$88,046,000**	**($9,184,000)**	**-9%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$237,732,000	$233,715,000	($4,017,000)	-2%
	Total Long Term Debt	**$237,732,000**	**$233,715,000**	**($4,017,000)**	**-2%**
3	Accrued Pension Liability	$227,408,000	$192,262,000	($35,146,000)	-15%
4	Other Long Term Liabilities	$51,868,000	$57,584,000	$5,716,000	11%
	Total Long Term Liabilities	**$517,008,000**	**$483,561,000**	**($33,447,000)**	**-6%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$49,222,000	$140,435,000	$91,213,000	185%
2	Temporarily Restricted Net Assets	$29,372,000	$29,334,000	($38,000)	0%
3	Permanently Restricted Net Assets	$55,311,000	$61,210,000	$5,899,000	11%
	Total Net Assets	**$133,905,000**	**$230,979,000**	**$97,074,000**	**72%**
	Total Liabilities and Net Assets	**$748,143,000**	**$802,586,000**	**$54,443,000**	**7%**

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,496	$2,472,109,000	$219,904,504	10%
2	Less: Allowances	$1,492,769,983	$1,670,729,000	$177,959,017	12%
3	Less: Charity Care	$14,403,000	$20,662,000	$6,259,000	43%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,513**	**$780,718,000**	**$35,686,487**	**5%**
5	Provision for Bad Debts	$14,575,173	$11,262,000	($3,313,173)	-23%
	Net Patient Service Revenue less provision for bad debts	**$730,456,340**	**$769,456,000**	**$38,999,660**	**5%**
6	Other Operating Revenue	$37,241,398	$43,979,000	$6,737,602	18%
7	Net Assets Released from Restrictions	$3,396,800	$3,869,000	$472,200	14%
	Total Operating Revenue	**$771,094,538**	**$817,304,000**	**$46,209,462**	**6%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,995,100	$245,787,000	($12,208,100)	-5%
2	Fringe Benefits	$64,720,593	$52,305,000	($12,415,593)	-19%
3	Physicians Fees	$52,216,369	$48,090,000	($4,126,369)	-8%
4	Supplies and Drugs	$113,739,471	$140,126,000	$26,386,529	23%
5	Depreciation and Amortization	$43,829,465	$38,485,000	($5,344,465)	-12%
6	Bad Debts	$0		$0	0%
7	Interest Expense	$8,464,953	$9,206,000	$741,047	9%
8	Malpractice Insurance Cost	$8,752,762	$9,905,000	$1,152,238	13%
9	Other Operating Expenses	$210,971,585	$231,207,000	$20,235,415	10%
	Total Operating Expenses	**$760,690,298**	**$775,111,000**	**$14,420,702**	**2%**
	Income/(Loss) From Operations	**$10,404,240**	**$42,193,000**	**$31,788,760**	**306%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,881,703	$10,954,000	$4,072,297	59%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,959,580)	($927,000)	$4,032,580	-81%
	Total Non-Operating Revenue	**$1,922,123**	**$10,027,000**	**$8,104,877**	**422%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Principal Payments	$0	$0	$0	0%

Attachment B Cash Flow

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	$ 52,220,000	$ 12,326,000
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	38,485,000	44,179,000
Bad debts	11,262,000	14,575,000
Transfers to Trinity Health and affiliates	26,733,000	
Decrease (increase) in interest in Saint Francis Hospital and Medical Center Foundation	3,069,000	(2,287,000)
Increase in assets held in trust by others	-	(2,132,000)
Change in retirement plan related items	7,812,000	
Increase in accrued pension liability	(35,146,000)	(7,978,000)
Increase (decrease) in other long term liabilities	5,716,000	(28,861,000)
Other changes in net assets	4,409,000	(13,637,000)
Change in working capital, other than cash and cash equivalents	(75,747,000)	(62,697,000)
Net cash provided (used) in operating activities	38,813,000	(46,512,000)
Investing activities		
Purchase of property, plant and equipment, net	(24,110,000)	(34,704,000)
Purchase accounting, property, plant and equipment		55,304,000
Increase in investments	(7,507,000)	(18,597,000)
Change in permanently restricted endowment	5,900,000	
Increase in other noncurrent assets		(5,685,000)
Increase in noncurrent assets whose use is limited	(9,130,000)	(2,423,000)
Net cash used in investing activities	(34,847,000)	(6,105,000)
Financing activities		
Principal payments on long-term debt	(5,181,000)	(6,795,000)
Net cash used in financing activities	(5,181,000)	(6,795,000)
Net decrease in cash and cash equivalents	(1,215,000)	(59,412,000)
Cash and cash equivalents at beginning of period	17,282,000	76,694,000
Cash and cash equivalents at end of period	$ 16,067,000	$ 17,282,000

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	$ 0	$ 1,521,000
Accounts receivable--patients, net	(11,469,000)	(17,231,000)
Other current assets	(14,027,000)	77,000
Due from third party reimbursement agencies	(732,000)	
Inventory of supplies	250,000	789,000
Prepaid expenses	1,461,000	4,079,000
Due from affiliated entities	(43,210,000)	(42,621,000)
	(67,727,000)	(53,386,000)
Changes in current liabilities:		
Accounts payable and accrued expenses	(5,042,000)	(12,329,000)
Salary and wages, payroll taxes and amounts withheld from employees	(7,072,000)	2,146,000
Other current liabilities	4,320,000	
Due to third party reimbursement agencies	(226,000)	872,000
	(8,020,000)	(9,311,000)
Changes in working capital other than cash and cash equivalents	$ (75,747,000)	$ (62,697,000)

Attachment C Financial Indicators

Saint Francis Hospital and Medical Center

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD	Comments
A. Operating Performance:			
Operating Margin	5.2%	1.3%	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	11.0%	8.1%	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	0.5%	0.6%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	2.8	1.9	current assets/current liabilites
Days Cash on Hand	42.7	49.7	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr
Days in Net Accounts Receivables	30.7	32.3	net ar/net patient ser rev(after bd)/days in yr
Average Payment Period	43.6	49.5	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	103.7%	182.7%	total debt/total equity(net assets)
Long-term Debt to Capitalization	50.3%	64.0%	LTD/LTD+net assets
Unrestricted Cash to Debt	36.0%	40.0%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	5.6	2.2	EBIT/Interest expense
Debt Service Coverage Ratio	6.0 x	4.1 x	(Net income+int+depr)/(st debt+int exp)
Equity Financing Ratio	28.8%	17.9%	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations	$ 42,193	$ 10,404	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 52,220	$ 12,326	Net gain(loss)
EBITDA	$ 89,884	$ 62,698	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 60,553	$ 54,908	from cons bs
Net Working Capital	$ 162,832	$ 91,538	current assets-current liabilities
Unrestricted Assets	$ 140,435	$ 49,222	from cons bs

Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis Care, Inc.

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulation 9 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Item #9 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

9. Within one hundred and fifty (150) days following the Closing Date and thereafter on an annual basis, the Applicants shall submit to OHCA its Capital Investment Plan specific to JMMC and JMH detailing the proposed allocation of the capital investment commitment over the three-year period post-closing. The submitted plans shall account for the full commitment as stated in this proposal and include the following in a format to be agreed upon:

> *a) A list of planned capital expenditures with detailed descriptions and associated estimated costs; and b) A timeframe for the roll out of the capital projects (including estimated beginning, ending and startup/operation dates); and c) Written reports updating OHCA on the implementation of the Capital Investment Plan in each Annual Report submitted under this Order. Such reports shall describe all activities and expenditures undertaken as part of the Capital Investment Plan, including but not limited to, a description of the capital project, the dates and amounts of withdrawals from the JMMC's operating account and/or any other sources of funding used to fulfill the capital commitment. The reports shall be signed by JMMC's Chief Financial Officer.*

Since the approval of the Certificate of Need, Johnson has been in the process of developing the capital budget for FY 2017 (July 1, 2016 through June 30, 2017).

For the period April 1, 2016 through September 30, 2016, Johnson incurred capital expenditures of $1.1 million (See **Attachment A**). As previously reported, Trinity Health – New England (formerly known as Saint Francis *Care,* Inc.*)* and Johnson accelerated the timing of the implementation of the Epic electronic medical record system. The total capital cost of this system implementation relating to Johnson was approximately $6.8 million, which was paid by Saint Francis Hospital and Medical Center and ultimately structured as a capital lease to Johnson. Annual capital lease payments from Johnson to Saint Francis Hospital and Medical Center total $960,000 annually for seven years, $480,000 for the six month period ended September 30, which has been included in the capital expenditure report attached.

The FY 2017-FY2020 preliminary capital budget for Johnson (see **Attachment B**) was developed as part of the Trinity Health-New England's capital and operating budget processes as well as the current strategic financial planning process for the fiscal years 2018-2020. While capital projects are inventoried and identified during the strategic planning process, the actual expenditure for FY 2017, 2018 and 2019 will likely be $1.5 million, $3.0 million and $3.0 million, respectively. Individual items on Johnson's capital request will be continuously evaluated as we are constantly assessing the strategic needs of the facilities.

Johnson Memorial Hospital/Johnson Memorial Medical Center
New Acquisition Jan - Sept 16
Stipulation # 9 Attachment A

Row Labels	Sum of ORIGINAL COST
1/1/2016	**$ 102,509**
AccuDose Door Lock	$ 50,603
MRI Portico work	$ 31,904
software	$ 13,053
(blank)	$ 6,949
2/1/2016	**$ 40,656**
HD LED CD monitor/stand/basket	$ 14,260
JSC humidity & temp control	$ 26,396
3/1/2016	**$ 43,475**
AccuDose Door Lock	$ 7,425
analog video monitor syste -icu	$ 4,987
Endo cleaning station	$ 7,312
JSC humidity & temp control	$ 4,695
pneumatic Tube system	$ 10,276
upgrad to hum/temp controls	$ 8,780
4/1/2016	**$ 55,385**
Anesthesia monitors- lease buyout	$ 12,000
Psych room renovations	$ 19,825
renov for steris washer/sink,counter	$ 11,900
Steris/Amsco Washer	$ 11,660
5/1/2016	**$ 111,352**
Centricity Perinatal Intrapartum System	$ 86,343
Cystoscope equipment	$ 25,009
6/1/2016	**$ 279,465**
EPIQ 7G Ultrasound System	$ 259,640
Psych room renovations	$ 19,825
7/1/2016	**$ 23,496**
Endo cleaning station	$ 17,061
LF-DP Tracheal Intubation Fib rscope	$ 6,435
8/1/2016	**$ 119,998**
Kawneed series alum doors	$ 7,750
PeopleSoft Licenses	$ 112,248
Grand Total	**$ 776,335**

Epic Capital Lease	$	720,000
Total Capital Expenditures including Lease 1/1-9/30	$	1,496,335
Total Capital Expenditures including Lease 4/1-9/30	$	1,069,696

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Plant Operations (8060)	Electrical upgrades - Phase One (FY18= $600k, FY19=$100k)	1		460,909	239,091		
Plant Operations (8060)	Kitchen Exhaust System	1		235,797			
Radiology (7240)	Digital Radiology room - remove old equip, install	1	R	210,000			
Nursing Admin (6010)	R Series ALC biphasic ZOLL Defibrillators (11 defibrillators)	1	R	208,611			
Plant Operations (8060)	Paving Visitor Parking Lot	2	R	126,165			
Plant Operations (8060)	Patient Room windows - recalk for blurry			50,000			
Pharmacy (7330)	Guardrails Service contract for Alaris IV pumps	1	R	72,000			
Plant Operations (8060)	Repairs to main Entrance Canopy	1		65,418			
Plant Operations (8060)	Uranium System	1		35,000			
Radiology (7240)	Raometeric - one for JSC & JMH	1	N	18,000			
Pharmacy (7330)	3-card reader controller Locks (2 Stfd, 1 Enf)	1	N	10,000			
Plant Operations (8060)	Remove & install new Fire Hydrant	1		8,100			
Pharmacy (7330)	IV room @ JMH	1	N		500,000		
Radiology (7240)	Digital Mammography upgrad 2D @ JSC and Digital @JMH	1	R		430,000		
Radiology (7240)	R&F Digital room - remove old equip, install	1	R		$369,750		
Pharmacy (7330)	AcuDose Equipment for OR suites @ JSC OR suites	1	N	-	274,001		
Radiology (7240)	GE OEC C-Arm	2	R		200,000		
Ultrasound (7280)	Ultrasound room & removal of old u/s equip	1	R		135,395		
Ultrasound (7280)	Philips EPIQ 7 Diamond Select System	1	R		118,000		
Plant Operations (8060)	Boiler,Energy Saving Controls/Hawk system	1	R		125,915		
Plant Operations (8060)	Paving Roadway, Loading Dock area, parking	2	R		$122,841		
Pharmacy (7330)	AcuDose Software Upgrade Connect	1	R		76,118		
Nursing Admin (6010)	Carefusion Alaris PCA modules, Unites, ETC02 modules	1	R		75,768		
Cardiolvascular (7250)	Cardiovascular Ultrasound Scanner	1	R		75,150		
Plant Operations (8060)	Bobcat for Snow removal & grounds work	2			$70,000		
Central Sterile Proc. (6760)	Getinge 733 sterilizer	1	N		69,636		
JSC (Surgery Ctr) (6600)	OR Surgical Lights in OR 1, 2 & 3	1	R		66,492		
Plant Operations (8060)	ABS - JMH OR/Pharmacy/Heat Exchanger	2			61,320		
Plant Operations (8060)	Lighting Protections: Main Bldg; BH; PH; & WWTP	2			$55,550		
Plant Operations (8060)	Truck	2			50,000		

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
JSC (Surgery Ctr) (6600)	Stryker Video Equipment Incl display & camera heads	2	R		40,101		
Enfield Phys Med (7093)	Mediware MediLinks OP CUL License	1	N		39,960		
Perioperative Svcs (6610)	Urology Instrumentation	1	R		34,000		
Nursing Admin (6010)	Carefusion Alaris syringe modules and software	2	R		33,252		
Nursing Admin (6010)	3 EZZ way 1000 lb ceiling lifts w continuous charge	2	N		32,262		
Plant Operations (8060)	Paint Boiler House Smoke Stack	2			$31,180		
Psychiatry (6070)	Psychiatric Safe Medical Beds - 5 beds @ $5,900	2	N		29,500		
CT Scan (7230)	ACR CT phantoms for JSC & JMH	1	N		26,000		
Plant Operations (8060)	I-Net Sysetm Upgrade	1			13,285		
Pharmacy (7330)	Camera Security System for pharm (4 Stfd, 2 Enf)	1	N		12,000		
Plant Operations (8060)	Fleet Guard Key System - control system	2			11,818		
Radiology (7240)	Stryker Stretcher - trauma - JMH	1	R		$9,100		
Plant Operations (8060)	Backup Myers Pump for Bed 6 WWTP	2			9,084		
Ultrasound (7280)	Stryker OB Stretcher for JSC	1	N		6,000		
Plant Operations (8060)	Install 9 bollards in front of Generator	1			$7,786		
	Carefusion					2,000,000	
	Pixis						
Nuclear Medicine (7300)	Siemens Symbia T6 Spect/CT camera	1	R			599,600	
CT Scan (7230)	Siemens Somatome Perspective 64 slice scanner	1	R			525,000	
Radiology (7240)	RadSpeed Auto Dr Radiographic Room	2	R			273,350	
Laboratory (7020)	Hematology replacemsnt (2) Sysmex XN2000 analyzers	2	R			173,918	
Same Day Surgury (6605)	GE patient monitors & Central station monitor	2	R			145,834	
Plant Operations (8060)	Hot Water System	3				130,000	
Laboratory (7020)	(2) ACL TOP 300 Coagulation analyzers	1	R			90,000	
Perioperative Svcs (6610)	Mammotome	1	N			$65,526	
Radiology (7240)	Bone Density (remove old equip, install)	3	R			65,000	
Central Sterile Proc. (6760)	Getinge 8668 Washer Disinfecter 12 Tray unit	3	N			55,598	
Plant Operations (8060)	Fuel duplex pump set	3				47,919	
Plant Operations (8060)	Medical Vacuum System	3				$31,997	
Respiratory Therapy (7400)	Maquet SERVO - 1 Universal Core	1	N			30,681	

Johnson Memorial Medical Center/Johnson Memorial Hospital

FY 2017 to FY 2020 Preliminary Capital Plan

Stipulation #9 Attachment B

N=New
R = Replace

Entity/Leader/Dept	Item Description	Priority		FY 2017	FY 2018	FY 2019	FY 2020
Cardiac Rehab (7590)	complete phase 3 of business plan for relocation	1	N			23,100	
Radiology (7240)	C-Arm Table	3	R			20,000	
Plant Operations (8060)	New Well Install #9 - LaFamboise	3				17,155	
Anesthesia (7370)	Glide Scope	1	R			$14,422	
CT Scan (7230)	Renovation of Ct area - stretcher, curtain, paint/floor		R			10,000	
Radiology (7240)	renovation of main xray viewing room		N			10,000	
Emergency Rm (6850)	Stryker Stretcher - Trauma/2 Big Wheel	1	N			9,405	
Post Anesthesia Care (6660	Transport Monitor	1	N	-		8,530	
Laboratory (7020)	Ortho Workstation for ID-MTS Gel Cards	1	N			7,060	
Central Sterile Proc. (6760)	Getinge Prep & Pack table	3	N			6,883	
Enfield Phys Med (7093)	NuStep Recumbent Cross Trainer w/oversized seat	2	R			6,670	
Laboratory (7020)	Hematology micro scope	1	R			$6,400	
CT Scan (7230)	Countertop Blanket Warmer		N			6,000	
Radiology (7240)	GE 9" Laser Aimer for OEC 9899 +C-Arm Part		N			6,000	
Enfield Phys Med (7093)	AC5000M Treadmill w handrails/wght cap of 550 lbs	3	R			4,972	
CT Scan (7230)	64 slice Ct Scanner with install & remove old equip,	2	R				$569,170
Plant Operations (8060)	Contingency - Emergency Repairs	3					500,000
Anesthesia (7370)	Anesthisia Machines	3	R				400,000
Plant Operations (8060)	Nirenberg - Generators	3					350,000
Grand Totals JMMC				$ 1,500,000	$ 3,450,355	$ 4,391,020	$ 1,819,170

Note: Based on current infrastructure issues at Johnson, the creation of a sewer system is expected over the next three years. The estimated costs for Johnson relating to this project is approximately $4.0 million. This amount is not included in the schedule above.

Trinity Health
Of New England

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

December 12, 2017

RE: Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Dear Ms. Roberts:

Please see the attached documents in satisfaction of Stipulations 10 and 11 of the above-referenced Agreed Settlement Order dated November 24, 2015.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

CON Docket Number: 15-32002-CON Transfer of Ownership of Johnson Memorial Medical Center to Saint Francis *Care,* Inc.

Response to Items #10 and #11 of the Settlement and Order dated 11/24/2015 for the Six Month Period Ended September 30, 2017

10. For three (3) years following the Closing Date, the Applicants shall file the following information with OHCA on a semi-annual basis for both JMH and its immediate parent, JMMC. For purposes of this Order, semi-annual periods are October 1- March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016:

a) The cost saving totals achieved in the following Operating Expense Categories for both JMH and its immediate parent, JMMC: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category; and

Since January 1, 2016, the leaders within the functional areas at Saint Francis Hospital and Medical Center have been working closely with Johnson to identify and implement changes to realize cost savings opportunities. As previously reported, one immediate benefit was the successful restructuring of Johnson's debt as of December 31, 2015 with an intercompany loan from Trinity Health Of New England Corporation, Inc. (TH Of NE). In addition, Saint Francis Hospital and Medical Center forgave a loan due from Johnson in the amount of $2,350,000 upon the closing of the transaction. The restructured debt has resulted in a decrease of interest expense in the amount of $48,000 for the six month period ended September 30, 2017.

Another significant savings realized to date was the inclusion of Johnson into the Trinity Health insurance program. This produced an overall decrease in annual premiums for malpractice, workers compensation and other business policies of approximately $1.0 million. Furthermore, additional insurance premium savings of $198,000 will be realized for the annual period 7/1/2017 through 6/30/2018. For the six month period ended September 30, 2017, the additional savings realized was approximately $100,000.

There continues to be significant efforts to centralize and regionalize support functions across TH Of NE including Finance, Human Resources, Revenue Cycle, Quality, Performance Improvement, Facilities, and Information Systems. In the last twelve months, HIM and Billing have fully integrated into TH Of NE. This has resulted in reduction of costs at Johnson of $1.2 million for the six months ended September 30, 2017 for all of these support areas.

In addition, Johnson has benefited from the utilization of both regional and system office Legal Services, Compliance and Audit departments. The decrease in legal fees, consulting and auditing costs associated with this transition was $258,000 for the six month period ended September 30, 2017.

Annual non-salary information technology costs of $308,000 were transferred to the region at the beginning of FY 2017. Other cost reductions due to regionalization were $47,000 and $43,000 in advertising and recruitment expenses. Johnson's portion of these costs are now included in the regional allocation.

The above savings are offset by a TH Of NE regional allocation of $706,000 for the six month period included in other operating expenses in **Attachment A.**

Another initiative to improve quality and decrease costs that occurred during FY 2017 was the restructuring of lab services utilizing Collaborative Laboratory Services ("CLS"). This restructure transitioned the lab personnel and purchasing of supplies from Johnson to CLS. As a result, Johnson is now charged a cost per RVU for lab tests performed from CLS. This integration of Johnson's lab with CLS has resulted in net savings of $328,000 for the six month period ended September 30, 2017. Currently, we are in the process of evaluating the regionalization of the Laboratory across the entire TH Of NE region.

As previously reported, during the first calendar quarter of 2017, the Enfield Oncology staff transitioned to employees of Saint Francis. This transition allows both Saint Francis and Johnson to share resources across both campuses, provide enhanced compensation packages for employees and has resulted in a lower cost to Johnson through this arrangement. Additional savings were realized as a result of this integration and the net benefit to Johnson was $142,000 for the six months ended September 30, 2017.

In addition to the cost savings, Johnson has been able to leverage the expertise and resources at Saint Francis Hospital and Medical Center, Trinity Health Of New England and Trinity Health in each of the areas identified above.

JMMC merged into JMH on January 23, 2017 and all savings related to this transaction were recognized in JMH prior to the merger

Lastly, TH Of NE working with Trinity Health has engaged consultants to continue to assist in performance improvement, integration, regionalization strategy, productivity improvements and other cost reductions. Resources from Trinity Health system office are supporting these efforts and are on-site on a regular basis. Furthermore, Trinity Health has assumed 50% of these costs totaling over $1.3 million benefit to the Connecticut hospitals within TH Of NE for the six month period.

We continue to identify cost saving opportunities as we align our vendor contracts with Trinity Health system contracts. Supply chain savings realized during the six month period was $28,000.

See **Attachment A** for expense savings by category. Also, refer to financial statistics noting significant improvement in financial performance since the acquisition of Johnson by TH Of NE.

2. the effect of these cost savings on the clinical quality of care.

There has been no negative impact to clinical quality of care as a result of these cost savings.

Since joining TH Of NE, Johnson has received the Gold Seal 3-year Joint Commission Accreditation, and has experienced improvements in both patient experience and clinical quality. With that said, Johnson is leading the region in three critical metrics: Hospital Acquired Infections, Readmission Rates and ED Patient Experience. Areas of clinical quality improvement have also resulted in decreased serious safety events.

Also, Johnson's average daily census and year-to-date discharges continue to remain strong and Johnson's overall financial performance has improved significantly since the affiliation. See **Attachment B** which highlights the overall decrease in costs per case mix adjusted equivalent at Johnson since the acquisition on January 1, 2016.

b) A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for JMH and its immediate parent, JMMC. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

See **Attachment C.**

11) For three (3) years following the Closing Date, SFCRHM shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data, and comparable prior year period data for the Hospital and for SFCRHM. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning May 31, 2016.

See **Attachment D** for Financial Indicators.

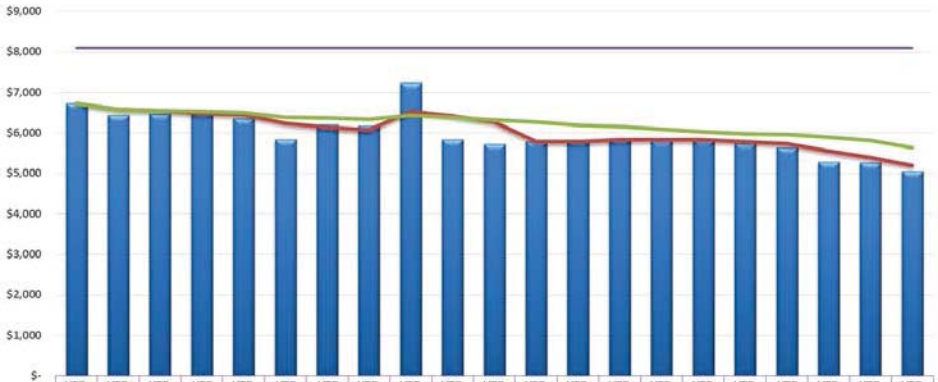
Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 4/1-9/30 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$2,140
B.	Fringe Benefits (pension and workers comp)	$428
C.	Contractual Labor Fees	($2,430)
D.	Medical Supplies and Pharmaceutical Cost	$843
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$48
H.	Malpractice Insurance Cost	$0
I.	Utilities	
J.	Business Expenses (insurance)	$101
K.	Other Operating Expense	$258
	Total savings 4/1-9/30	$1,388

Attachment B

Johnson Memorial Hospital Cost Analysis
Costs per Case Mix Adjusted Equivalent Discharge (CMAED)



	YTD Jan-16	YTD Feb-16	YTD Mar-16	YTD Apr-16	YTD May-16	YTD Jun-16	YTD Jul-16	YTD Aug-16	YTD Sept-16	YTD Oct-16	YTD Nov-16	YTD Dec-16	YTD Jan-17	YTD Feb-17	YTD Mar-17	YTD Apr-17	YTD May-17	YTD Jun-17	YTD Jul-17	YTD Aug-17	YTD Sep-17
Cost per CMAED	6,726	6,437	6,470	6,529	6,356	5,835	6,204	6,170	7,242	5,840	5,717	5,779	5,825	5,861	5,808	5,815	5,738	5,641	5,272	5,263	5,049
3 month mov average	6,726	6,582	6,545	6,479	6,452	6,240	6,132	6,070	6,539	6,418	6,266	5,779	5,773	5,822	5,831	5,828	5,787	5,731	5,551	5,392	5,195
12 month mov average	6,726	6,582	6,545	6,541	6,504	6,392	6,365	6,341	6,441	6,381	6,321	6,276	6,200	6,152	6,097	6,038	5,986	5,970	5,892	5,817	5,634
Goal	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108

Per HFM KFI YTD

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,696,172	$1,865,864	$169,692	10%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$6,738,696	($10,678,003)	-61%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$2,060,646	$547,173	36%
8	Prepaid Expenses	$676,712	$941,512	$264,800	39%
9	Other Current Assets	$3,525,137	$1,417,841	($2,107,296)	-60%
	Total Current Assets	**$24,828,193**	**$13,024,559**	**($11,803,634)**	**-48%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,000,925	($201,240)	-6%
7	Other Noncurrent Assets	$805,530	$679,961	($125,569)	-16%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$28,194,191	$7,447,016	36%
2	Less: Accumulated Depreciation	$861,533	$3,484,320	$2,622,787	304%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,709,871**	**$4,824,229**	**24%**
3	Construction in Progress	$870,370	$867,879	($2,491)	0%
	Total Net Fixed Assets	**$20,756,012**	**$25,577,750**	**$4,821,738**	**23%**
	Total Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$2,835,389	($1,647,081)	-37%
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,489,870	$358	0%

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
3	Due To Third Party Payers	$843,823	$2,051,852	$1,208,029	143%
4	Due To Affiliates	$23,268,975	$8,077,987	($15,190,988)	-65%
5	Current Portion of Long Term Debt	$0	$0	$0	0%
6	Current Portion of Notes Payable	$992,452	$662,874	($329,578)	-33%
7	Other Current Liabilities	$531,683	$396,731	($134,952)	-25%
	Total Current Liabilities	**$32,608,915**	**$16,514,703**	**($16,094,212)**	**-49%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$21,457,110	$21,256,398	($200,712)	-1%
	Total Long Term Debt	**$21,457,110**	**$21,256,398**	**($200,712)**	**-1%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$1,152,091	$1,225,411	$73,320	6%
	Total Long Term Liabilities	**$22,609,201**	**$22,481,809**	**($127,392)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,634,070	$8,802,759	-143%
2	Temporarily Restricted Net Assets	$542,473	$652,613	$110,140	20%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$3,286,683**	**$8,912,899**	**-158%**
	Total Liabilities and Net Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	JAN - SEPT	SEPTEMBER	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$125,148,528	$175,765,124	$50,616,596	40%
2	Less: Allowances	$75,020,725	$110,810,545	$35,789,820	48%
3	Less: Charity Care	$106,845	$0	($106,845)	-100%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$50,020,958**	**$64,954,579**	**$14,933,621**	**30%**
5	Provision for Bad Debts	$2,839,922	$2,354,604	($485,318)	-17%
	Net Patient Service Revenue less provision for bad debts	**$47,181,036**	**$62,599,975**	**$15,418,939**	**33%**
6	Other Operating Revenue	$433,585	$1,794,264	$1,360,679	314%
7	Net Assets Released from Restrictions	$9,000	$23,149	$14,149	157%
	Total Operating Revenue	**$47,623,621**	**$64,417,388**	**$16,793,767**	**35%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$19,306,685	$22,387,242	$3,080,557	16%
2	Fringe Benefits	$4,538,798	$4,723,464	$184,666	4%
3	Physicians Fees	$4,080,467	$5,923,698	$1,843,231	45%
4	Supplies and Drugs	$7,477,413	$10,598,733	$3,121,320	42%
5	Depreciation and Amortization	$2,385,036	$2,408,210	$23,174	1%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$646,780	$796,688	$149,908	23%
8	Malpractice Insurance Cost	$102,815	$164,120	$61,305	60%
9	Other Operating Expenses	$12,312,821	$16,792,654	$4,479,833	36%
	Total Operating Expenses	**$50,850,815**	**$63,794,809**	**$12,943,994**	**25%**
	Income/(Loss) From Operations	**($3,227,194)**	**$622,579**	**$3,849,773**	**-119%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0	$0	$0	0%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($246,748)	($25,088)	$221,660	-90%
	Total Non-Operating Revenue	**($246,748)**	**($25,088)**	**$221,660**	**-90%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($3,473,942)**	**$597,491**	**$4,071,433**	**-117%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$300,649	$300,649	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$300,649**	**$300,649**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**($3,473,942)**	**$898,140**	**$4,372,082**	**-126%**
	Principal Payments	$109,419	$1,213,306	$1,103,887	1009%

Attachment C

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	September 30 2017	September 30 2016
Operating activities and non-operating income		
Excess (deficiency) of revenues over expenses	**$ 59,054**	**$ (3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**2,449,027**	**2,481,154**
Bad debts	**2,920,770**	**3,183,064**
Increase in pension and other accrued expenses	**73,320**	**801,386**
Other changes in net assets	**69,546**	**96,063**
Change in working capital, other than cash and cash equivalents	**(2,409,392)**	**2,513,860**
Net cash provided by operating activities	**3,162,325**	**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net	**(2,818,652)**	**(1,679,032)**
Decrease in long term investments	**201,240**	**269,872**
(Increase) decrease in other assets	**125,569**	**(798,396)**
Net cash used in investing activities	**(2,491,843)**	**(2,207,556)**
Financing activities		
Principal payments on long-term debt	**(530,290)**	**(819,824)**
Net cash used in financing activities	**(530,290)**	**(819,824)**
Net increase in cash and cash equivalents	**140,192**	**2,059,069**

Attachment D

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

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD*	Comments
A. Operating Performance:			
Operating Margin	1.0%	(6.8%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	5.9%	(0.4%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.6%	2.3%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	11.1	9.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	37.9	100.8	net ar/net patient ser rev/days in yr
Average Payment Period	98.2	183.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	666.8%	(399.0%)	total debt/total equity(net assets)
Long-term Debt to Capitalization	86.6%	135.5%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.5%	7.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	1.8	(4.0)	EBIT/Interest expense
Debt Service Coverage Ratio	2.62	(0.12)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	7.8%	(11.3%)	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ 623	$ (3,227)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 898	$ (3,474)	Net gain(loss)
EBIDA	$ 3,828	$ (195)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,866	$ 1,696	from bs
Net Working Capital	$ (3,490)	$ (7,781)	current assets-current liabilities
Unrestricted Assets	$ 2,634	$ (6,169)	from bs

*1/1/-9/30/16

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$1,696,172	$1,865,864	$169,692	10%
2	Short Term Investments	$0	$0	$0	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$17,416,699	$6,738,696	($10,678,003)	-61%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,513,473	$2,060,646	$547,173	36%
8	Prepaid Expenses	$676,712	$941,512	$264,800	39%
9	Other Current Assets	$3,525,137	$1,417,841	($2,107,296)	-60%
	Total Current Assets	**$24,828,193**	**$13,024,559**	**($11,803,634)**	**-48%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$0	$0	$0	0%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**	**$0**	**0%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$3,202,165	$3,000,925	($201,240)	-6%
7	Other Noncurrent Assets	$805,530	$679,961	($125,569)	-16%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$20,747,175	$28,194,191	$7,447,016	36%
2	Less: Accumulated Depreciation	$861,533	$3,484,320	$2,622,787	304%
	Property, Plant and Equipment, Net	**$19,885,642**	**$24,709,871**	**$4,824,229**	**24%**
3	Construction in Progress	$870,370	$867,879	($2,491)	0%
	Total Net Fixed Assets	**$20,756,012**	**$25,577,750**	**$4,821,738**	**23%**
	Total Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$4,482,470	$2,835,389	($1,647,081)	-37%

Attachment C

JOHNSON MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(3)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	SEPTEMBER	DIFFERENCE	DIFFERENCE
2	Salaries, Wages and Payroll Taxes	$2,489,512	$2,489,870	$358	0%
3	Due To Third Party Payers	$843,823	$2,051,852	$1,208,029	143%
4	Due To Affiliates	$23,268,975	$8,077,987	($15,190,988)	-65%
5	Current Portion of Long Term Debt	$0	$0	$0	0%
6	Current Portion of Notes Payable	$992,452	$662,874	($329,578)	-33%
7	Other Current Liabilities	$531,683	$396,731	($134,952)	-25%
	Total Current Liabilities	**$32,608,915**	**$16,514,703**	**($16,094,212)**	**-49%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$0	$0	$0	0%
2	Notes Payable (Net of Current Portion)	$21,457,110	$21,256,398	($200,712)	-1%
	Total Long Term Debt	**$21,457,110**	**$21,256,398**	**($200,712)**	**-1%**
3	Accrued Pension Liability	$0	$0	$0	0%
4	Other Long Term Liabilities	$1,152,091	$1,225,411	$73,320	6%
	Total Long Term Liabilities	**$22,609,201**	**$22,481,809**	**($127,392)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	($6,168,689)	$2,634,070	$8,802,759	-143%
2	Temporarily Restricted Net Assets	$542,473	$652,613	$110,140	20%
3	Permanently Restricted Net Assets	$0	$0	$0	0%
	Total Net Assets	**($5,626,216)**	**$3,286,683**	**$8,912,899**	**-158%**
	Total Liabilities and Net Assets	**$49,591,900**	**$42,283,195**	**($7,308,705)**	**-15%**

Attachment D

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

Johnson Memorial Hospital

Monthly Financial Measurement/Indicators	Sept 17 YTD	Sept 16 YTD*	Comments
A. Operating Performance:			
Operating Margin	1.0%	(6.8%)	operating income/operating revenues
Non-Operating Margin	NA	NA	
Total Margin	5.9%	(0.4%)	Operating cash flow margin (EBIDA/operating revenue)
Bad Debt as % of Gross Revenue	1.6%	2.3%	bad debt/total patient serv. Revenue(before allowances)
B. Liquidity:			
Current Ratio	0.8	0.8	current assets/current liabilites
Days Cash on Hand	11.1	9.6	(cash and cash equiv+board restr. cash)/(total exp-depr)/YTD
Days in Net Accounts Receivables	37.9	100.8	net ar/net patient ser rev/days in yr
Average Payment Period	98.2	183.7	current liabilities/(total exp-depr)/YTD days in yr
C. Leverage and Capital Structure:			
Long-term Debt to Equity	666.8%	(399.0%)	total debt/total equity(net assets)
Long-term Debt to Capitalization	86.6%	135.5%	LTD/LTD+net assets
Unrestricted Cash to Debt	8.5%	7.6%	(cash and cash equiv+board restr. cash)/total debt (lt & st)
Times Interest Earned Ratio	1.8	(4.0)	EBIT/Interest expense
Debt Service Coverage Ratio	2.62	(0.12)	(Net inc+int+depr)/(st debt+int exp)
Equity Financing Ratio	7.8%	(11.3%)	Net assets/total assets
D. Additional Statistics (in thousands)			
Income(Loss) from Operations**	$ 623	$ (3,227)	Net income(loss) from operations
Revenue Over/(Under) Expense	$ 898	$ (3,474)	Net gain(loss)
EBIDA	$ 3,828	$ (195)	based on net income(loss) from operations
Patient Cash Collected	NA	NA	
Cash and Cash Equivalents	$ 1,866	$ 1,696	from bs
Net Working Capital	$ (3,490)	$ (7,781)	current assets-current liabilities
Unrestricted Assets	$ 2,634	$ (6,169)	from bs

*1/1/-9/30/16

Attachment B Cash Flow

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CASH FLOW

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Operating activities and non-operating income		
Excess of revenues over expenses	**$ 52,220,000**	**$ 12,326,000**
Adjustments to reconcile excess of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**38,485,000**	**44,179,000**
Bad debts	**11,262,000**	**14,575,000**
Transfers to Trinity Health and affiliates	**26,733,000**	
Decrease (increase) in interest in Saint Francis Hospital and Medical Center Foundation	**3,069,000**	**(2,287,000)**
Increase in assets held in trust by others	**-**	**(2,132,000)**
Change in retirement plan related items	**7,812,000**	
Increase in accrued pension liability	**(35,146,000)**	**(7,978,000)**
Increase (decrease) in other long term liabilities	**5,716,000**	**(28,861,000)**
Other changes in net assets	**4,409,000**	**(13,637,000)**
Change in working capital, other than cash and cash equivalents	**(75,747,000)**	**(62,697,000)**
Net cash provided (used) in operating activities	**38,813,000**	**(46,512,000)**
Investing activities		
Purchase of property, plant and equipment, net	**(24,110,000)**	**(34,704,000)**
Purchase accounting, property, plant and equipment		**55,304,000**
Increase in investments	**(7,507,000)**	**(18,597,000)**
Change in permanently restricted endowment	**5,900,000**	
Increase in other noncurrent assets		**(5,685,000)**
Increase in noncurrent assets whose use is limited	**(9,130,000)**	**(2,423,000)**
Net cash used in investing activities	**(34,847,000)**	**(6,105,000)**
Financing activities		
Principal payments on long-term debt	**(5,181,000)**	**(6,795,000)**
Net cash used in financing activities	**(5,181,000)**	**(6,795,000)**
Net decrease in cash and cash equivalents	**(1,215,000)**	**(59,412,000)**
Cash and cash equivalents at beginning of period	**17,282,000**	**76,694,000**
Cash and cash equivalents at end of period	**$ 16,067,000**	**$ 17,282,000**

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
CONSOLIDATED STATEMENT OF CHANGES IN COMPONENTS OF WORKING CAPITAL OTHER THAN CASH AND CASH EQUIVALENTS

	Twelve Months Ended September 30 2017	Twelve Months Ended September 30 2016
Changes in current assets:		
Assets whose use is limited required for current liabilities	**$ 0**	**$ 1,521,000**
Accounts receivable--patients, net	**(11,469,000)**	**(17,231,000)**
Other current assets	**(14,027,000)**	**77,000**
Due from third party reimbursement agencies	**(732,000)**	
Inventory of supplies	**250,000**	**789,000**
Prepaid expenses	**1,461,000**	**4,079,000**
Due from affiliated entities	**(43,210,000)**	**(42,621,000)**
	(67,727,000)	**(53,386,000)**
Changes in current liabilities:		
Accounts payable and accrued expenses	**(5,042,000)**	**(12,329,000)**
Salary and wages, payroll taxes and amounts withheld from employees	**(7,072,000)**	**2,146,000**
Other current liabilities	**4,320,000**	
Due to third party reimbursement agencies	**(226,000)**	**872,000**
	(8,020,000)	**(9,311,000)**
Changes in working capital other than cash and cash equivalents	**$ (75,747,000)**	**$ (62,697,000)**

Attachment A

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 10/1/2016-3/31/2017 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	
B.	Fringe Benefits (pension)	$3,100
C.	Contractual Labor Fees	
D.	Medical Supplies and Pharmaceutical Cost	$760
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$430
H.	Malpractice Insurance Cost	$1,100
I.	Utilities	
J.	Business Expenses (insurance and IT)	
K.	Other Operating Expense	$400
	Total savings 10/1-3/31	$5,790

Saint Mary's Hospital (hospital only)	Month		Year to Date	
	Sep 2017	Prior Year	Sep 2017	Prior Year
A. Operating Performance				
Operating Margin	2.6%	10.9%	8.7%	10.6%
Non-Operating Margin	0.6%	0.1%	0.4%	0.4%
Total Margin	3.1%	11.0%	9.1%	11.0%
Bad Debt as % of Gross Revenue	1.6%	0.1%	0.8%	0.8%
B. Liquidity				
Current Ratio	1.48	1.80	1.48	1.80
Days Cash on Hand	17	32	17	32
Days in Net Accounts Receivable	42	36	42	36
Average Payment Period	46	56	46	56
C. Leverage and Capital Structure				
Long-term Debt to Equity	0.33	0.00	0.33	0.00
Long-term Debt to Capitalization	0.25	0.00	0.25	0.00
Unrestricted Cash to Debt	0.48	231.74	0.48	231.74
Times Interest Earned Ratio	9.9	1177.1	104.71	159.03
Debt Service Coverage Ratio	31.4	138.1	53.04	125.89
Equity Financing Ratio	3.14	2.62	3.14	2.62
D. Additional Statistics				
Income from Operations	$ 588	$ 2,523	$ 24,324	$ 30,086
Revenue Over/(Under) Expense	$ 721	$ 2,537	$ 25,488	$ 31,138
EBITDA	$ 2,040	$ 3,867	$ 40,897	$ 42,424
Patient Cash Collected	$ 19,564	$ 20,601	$ 258,671	$ 259,506
Cash and Cash Equivalents	$ 12,027	$ 20,572	$ 12,027	$ 20,572
Net Working Capital	$ 8,303	$ 19,097	$ 8,303	$ 19,097
Unrestricted Assets	$ 56,185	$ 62,163	$ 56,185	$ 62,163
Credit Ratings (S&P, FITCH and Moody's)				

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$916,268,000	$978,048,000	$61,780,000	7%
2	Less: Allowances	$593,367,000	$654,455,000	$61,088,000	10%
3	Less: Charity Care	$6,950,000	$9,014,000	$2,064,000	30%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$315,951,000**	**$314,579,000**	**($1,372,000)**	**0%**
5	Provision for Bad Debts	$8,969,000	$9,041,000	$72,000	1%
	Net Patient Service Revenue less provision for bad debts	**$306,982,000**	**$305,538,000**	**($1,444,000)**	**0%**
6	Other Operating Revenue	$10,321,000	$13,807,000	$3,486,000	34%
7	Net Assets Released from Restrictions	$0	$0	$0	0%
	Total Operating Revenue	**$317,303,000**	**$319,345,000**	**$2,042,000**	**1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$132,586,000	$141,975,000	$9,389,000	7%
2	Fringe Benefits	$33,001,000	$22,785,000	($10,216,000)	-31%
3	Physicians Fees	$18,159,000	$15,701,000	($2,458,000)	-14%
4	Supplies and Drugs	$46,930,000	$48,790,000	$1,860,000	4%
5	Depreciation and Amortization	$12,879,000	$17,455,000	$4,576,000	36%
6	Bad Debts	$0	$0	$0	0%
7	Interest Expense	$218,000	$275,000	$57,000	26%
8	Malpractice Insurance Cost	$2,289,000	$4,415,000	$2,126,000	93%
9	Other Operating Expenses	$62,569,000	$69,004,000	$6,435,000	10%
	Total Operating Expenses	**$308,631,000**	**$320,400,000**	**$11,769,000**	**4%**
	Income/(Loss) From Operations	**$8,672,000**	**($1,055,000)**	**($9,727,000)**	**-112%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$1,361,000	$1,636,000	$275,000	20%
2	Gifts, Contributions and Donations		$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$138,000	$42,000	($96,000)	-70%
	Total Non-Operating Revenue	**$1,499,000**	**$1,678,000**	**$179,000**	**12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%

SAINT MARY`S HEALTH SYSTEM (Consolidated)

TWELVE MONTHS ACTUAL FILING

12 MONTHS ENDED SEPTEMBER 30, 2017 AND 2016

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$10,171,000**	**$623,000**	**($9,548,000)**	**-94%**

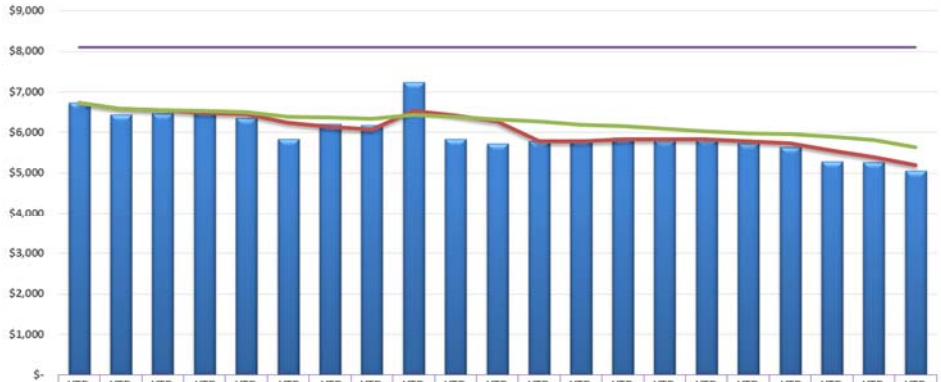
Attachment C

JOHNSON MEMORIAL MEDICAL CENTER, INC.
CONSOLIDATED STATEMENT OF CASH FLOW

	September 30 2017	September 30 2016
Operating activities and non-operating income		
Excess (deficiency) of revenues over expenses	**$ 59,054**	**$ (3,989,078)**
Adjustments to reconcile deficiency of revenues over expenses to net cash provided in operating activities and non-operating activities:		
Depreciation and amortization	**2,449,027**	**2,481,154**
Bad debts	**2,920,770**	**3,183,064**
Increase in pension and other accrued expenses	**73,320**	**801,386**
Other changes in net assets	**69,546**	**96,063**
Change in working capital, other than cash and cash equivalents	**(2,409,392)**	**2,513,860**
Net cash provided by operating activities	**3,162,325**	**5,086,449**
Investing activities		
Purchase of property, plant and equipment, net	**(2,818,652)**	**(1,679,032)**
Decrease in long term investments	**201,240**	**269,872**
(Increase) decrease in other assets	**125,569**	**(798,396)**
Net cash used in investing activities	**(2,491,843)**	**(2,207,556)**
Financing activities		
Principal payments on long-term debt	**(530,290)**	**(819,824)**
Net cash used in financing activities	**(530,290)**	**(819,824)**
Net increase in cash and cash equivalents	**140,192**	**2,059,069**

Attachment B

Johnson Memorial Hospital Cost Analysis
Costs per Case Mix Adjusted Equivalent Discharge (CMAED)



	YTD Jan-16	YTD Feb-16	YTD Mar-16	YTD Apr-16	YTD May-16	YTD Jun-16	YTD Jul-16	YTD Aug-16	YTD Sept-16	YTD Oct-16	YTD Nov-16	YTD Dec-16	YTD Jan-17	YTD Feb-17	YTD Mar-17	YTD Apr-17	YTD May-17	YTD Jun-17	YTD Jul-17	YTD Aug-17	YTD Sep-17
Cost per CMAED	6,726	6,437	6,470	6,529	6,356	5,835	6,204	6,170	7,242	5,840	5,717	5,779	5,825	5,861	5,808	5,815	5,738	5,641	5,272	5,263	5,049
3 month mov average	6,726	6,582	6,545	6,479	6,452	6,240	6,132	6,070	6,539	6,418	6,266	5,779	5,773	5,822	5,831	5,828	5,787	5,731	5,551	5,392	5,195
12 month mov average	6,726	6,582	6,545	6,541	6,504	6,392	6,365	6,341	6,441	6,381	6,321	6,276	6,200	6,152	6,097	6,038	5,986	5,970	5,892	5,817	5,634
Goal	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108	8,108

Per HFM KFI YTD

Attachment A

Johnson Memorial Hospital
Cost Savings/Synergies 4/1/2017-9/30/2017

LINE	DESCRIPTION	Savings 4/1-9/30 (In 000's)
I.	**OPERATING EXPENSE BY CATEGORY**	
A.	Salaries & Wages	$2,140
B.	Fringe Benefits (pension and workers comp)	$428
C.	Contractual Labor Fees	($2,430)
D.	Medical Supplies and Pharmaceutical Cost	$843
E.	Depreciation and Amortization	
F.	Bad Debts	
G.	Interest Expense	$48
H.	Malpractice Insurance Cost	$0
I.	Utilities	
J.	Business Expenses (insurance)	$101
K.	Other Operating Expense	$258
	Total savings 4/1-9/30	$1,388

Attachment B

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$2,252,204,496	$2,472,109,000	$219,904,504	10%
2	Less: Allowances	$1,492,769,983	$1,670,729,000	$177,959,017	12%
3	Less: Charity Care	$14,403,000	$20,662,000	$6,259,000	43%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$745,031,513**	**$780,718,000**	**$35,686,487**	**5%**
5	Provision for Bad Debts	$14,575,173	$11,262,000	($3,313,173)	-23%
	Net Patient Service Revenue less provision for bad debts	**$730,456,340**	**$769,456,000**	**$38,999,660**	**5%**
6	Other Operating Revenue	$37,241,398	$43,979,000	$6,737,602	18%
7	Net Assets Released from Restrictions	$3,396,800	$3,869,000	$472,200	14%
	Total Operating Revenue	**$771,094,538**	**$817,304,000**	**$46,209,462**	**6%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$257,995,100	$245,787,000	($12,208,100)	-5%
2	Fringe Benefits	$64,720,593	$52,305,000	($12,415,593)	-19%
3	Physicians Fees	$52,216,369	$48,090,000	($4,126,369)	-8%
4	Supplies and Drugs	$113,739,471	$140,126,000	$26,386,529	23%
5	Depreciation and Amortization	$43,829,465	$38,485,000	($5,344,465)	-12%
6	Bad Debts	$0		$0	0%
7	Interest Expense	$8,464,953	$9,206,000	$741,047	9%
8	Malpractice Insurance Cost	$8,752,762	$9,905,000	$1,152,238	13%
9	Other Operating Expenses	$210,971,585	$231,207,000	$20,235,415	10%
	Total Operating Expenses	**$760,690,298**	**$775,111,000**	**$14,420,702**	**2%**
	Income/(Loss) From Operations	**$10,404,240**	**$42,193,000**	**$31,788,760**	**306%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$6,881,703	$10,954,000	$4,072,297	59%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($4,959,580)	($927,000)	$4,032,580	-81%
	Total Non-Operating Revenue	**$1,922,123**	**$10,027,000**	**$8,104,877**	**422%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0	$0	$0	0%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$0**	**$0**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$12,326,363**	**$52,220,000**	**$39,893,637**	**324%**
	Principal Payments	$0	$0	$0	0%

Type
Row Labels
Expansion/renovations of clinical facilities
1960 St. Franics Hospital& Medical center/Child Advo Access Control
4-2 Enhancements
5-2 CARDIOVASCULAR RENOVATION
6-2 Renovations
8-1, 8-1A ONCOLOGY RENOVATIONS
8-2 RENOVATION
95 WOODLAND-PERI-OP
A/E DESIGN REDERINGS 8-1, 8-1a & 8-2
CATH LAB RENOVATION AND REPLACEMENT
CJRI TWO O.R.s - Should be Closed to Dept# 50020 Per Rob Beeman
CWHC BUILD OUT
Digital Rad/Fluoro Suite
Furniture - Clinical Dept, Patient Family rm furniture update for 7-1/ 7-2
Gengras Dental Facility Renovations
JTO ROOM REPLACEMENTS (10 RMS)
Light Surgical
MAJOR BUILDING RENOVATION (34201)
Modify Fresh tissue lab and break room
MSH-Suisman 1st Fl - Pharmacy compounding Room
OR Floor Renovations - 6 ORs (Ambulatory)
OUTPATIENT CHF CENTER RENOVATIONS
Pharmacy upgrade
Purchase install new compounding pharmacy for Enfield Infusion center
RENOVATE 2107A , AND SUITE 1006 FOR PEDS AND OB
Small renovation of Cancer Center research lab
Waiting Room Chairs
Facility & program improvements for various service lines (e.g., CJRI, Rehab)
Auxiliary Annual Donation
Carepoint Workstations (ED)
DeMayo Knee Positioners
Midex Rex Drills(Spine Surgery
OSI Spine Table
PCS Support - Philanthropy
Radiologist/PACS/Reading Workstations
Replace Subaru Outback 2008 with 210000 miles oil leak
Replacment of the treatment planning system; Pinncle and transition to Raytstation.
Reupholster dad sleeper chairs in Labor & Delivery
Specialty Instruments-Dr. Gupta
Stryker Power Equipment
Stryker Sonopet (Qty 2) Spine and OR
Tables and Chairs
Women's Aux. Cap- May 16
Information Technology

4 laptops with docking stations
Cisco Telephones SFHMC FY2016 - 1842
EMC ARCHIVE TO MIGRATE DATA FROM CAREMEDIC
EMC PROJECT-BUILD AND ARCHIVE SFS DATA TO EMC
EPIC-PHASE 2 (PHASE 1 CIP1253)
Hardware General, IT Refresh
Infrastructure Movement and Replacmement of Data Center
Laptop PC, Oxycon Device,..
Nortel PBX Replacement
PC On wheels-Nursing 4-2
Software-General OB Server
Wi-Fi Equipment
Wireless Access Points-SFH
Workstation, Workstation on wheels

Investment in facilities, medical and non-medical equipment and technology

iViz Ultrasound System
103 WOODLAND DESIGN WORK
204 Manual Exam Table
4 Heat Exchangers-Cancer Center
ACCESS CONTROL SYSTEM-ELEVATOR AND DOOR SWIPES
Artic Sun
Beachchair Positioner
Bed Replacement
Build 4 Workstations in 4302
Building 2 Cooling Tower Repairs
Cardiac monitor units
CardioQuip Heater Cooler
CBO
Cellutome Control Unit
Chicago Stacker/Conveyer
Chiller - Re-Build of Chiller#2/#3
Collins garage parking gates
COLLINS GARAGE REPAIRS
Commercial Vacuum Stand 24"
Compressor Replacement on DAIK
Construction General - Replace OR doors - 1902
CREATE DOORWAY AND PAINT
CVOR Retractor
CWHC SHELL SPACE
Cysto Table
Digital Pathology
Dr. Grey's Office
ED Equipment
ED Equipment-Stretchers
ED Equipment-Ultrasounds
ED Stretchers
Electric Exam Table w/Stirrups

Electric Pallet Truck
Emergency replacement of main breaker on JTO Emergency Generatoir
Enclosure for MSC Loading Dock
Energy Audit-SFHMC, RHHCT, & JMMC
ESU Replacements
EXPAND EXECUTIVE OFFICES
FACILITIES GEN. - RENOV-ELECT.WHOLESALERS FACILITY FOR PARKING
FACILITIES GENERAL - RESTORE MASONRY ON BUILDINGS
FEES Camera
Follett Symphony plus ice and water dispenser
Furniture - Clinical Dept, Waiting Room Furniture L&D
Gem Premier 4000 pH/Blood Gas System
Generator Emergency - Replace the 400KW Building 1 Generator
GENGRAS 5TH FLOOR RENOVATIONS
HVAC - Air-conditioner - HVAC - AHU - Replace S-6 In Lower Penthouse in B-2
HVAC - Air-conditioner - Isolation Rooms Upgrade for PCT
HVAC-6N ADRC ADMIN. HVAC
Improvements and furniture for Suite 2107A
Install door and wall protection at CAPS
Install Second PCT Patient Toilet Grab Bars
KITCHEN ELEVATOR OVERHAUL
Light Exterior - Signage Lighting and Pole for Davita entrance
Lost ultdev01/us.s VAC Ultra T
Medical Equipment General - Foot Sets
Medivator Washers
Miscellaneous General - Trinity Signage
Monitor System - 3-5 Physio Monitor Replacement (16 pt)
Monitor System - Endoscopy - Anesthesiology Physio Monitoring EPIC Connectivity
Monitor System - Radiology Nursing Physio Monitor Replacement
Natus Vision EEG system
O2 blenders for NICU
Olympus Scope
Omni beds
Optimization & Load Demand Management
OR Tables (Skytron)
Other - Genesis Rigid Containers
Pacemaker - Replace Obsolete External Pacemakers
Pain Clinic Monitors
Perfusion Data Management System
Philips EPIQ 7 Echo Machine
Philips Transport Monitors
Plastic Hand Sets
Prevac Sterilizer Upgrade
Purchase Cryo Console
Purchase LifePak
Ready Dock Machine to Disinfect Mobile Devices
Recliners

RENOVATE 1-4 TO INCLUDE BED REPAIR ROOM & EMERGENCY OPEN CNTR
renovate suite 3206A for new compliance office
REPAIR OIL PIPING ON FUEL TANK AT SF CAMPUS
Repair/Replace Steam Traps-MSCMP
Repair/Replace Steam Traps-SFCMP
Replace Broken Ice Machine
REPLACE COLLINS GARAGE RUSTED CONDUITS/WIRING
Replace Dearatoron boiler system
Replace Nurse Call Center (AM2016-015)
REPLACE OBSOLETE PANELS
Replace portable X-Ray Units(2)/Replace X-Ray Rad Room
Replace two rotted and leaking water lines
Replacement - Ice & Water Dispenser
ROOF - REPLACEMENT OF FAILING ROOFS AT NORTH CAMPUS
Roofing-Gengras Building FY2017
SERVICE SWITCHGEARS IN BUILDING 1 AND 95 WOODLAND
Smith & Nephew Beach Chair positioner
SOLAR PANEL INSTALLATION
SPY Intraoperative Laser Angio
Surgery - Large Plastic Sets
System EP Navigation - Bard PRO EP Recording System Upgrade Windows 7
System Fire Detection - Siemens Fire Alarm Panel Replacement - 606
System Vacuum - Replace med gas and vacuum system components
Total Hip General Instrument Sets x 4
Trigger attachment replacement for Linvatech power drill
Trophon Machine
Ultrasound IV Guide Machine
Ultrasound Machine w/Probes
Urology Laser
Urology Scopes (2)
Verathon Glidescope
Vest System
water/ice machines
Window Replacement Project
WINDOWS REPLACEMENT PROGRAM LAST PHASE B5 AND B6-110

Physician acquisitions/ambulatory network development

ASC PROJECT (PLANNING, DESIGN & CONSTRUCTION)
Build out St 205 - 35 Nod Rd Avon
LogiqS8 ultrasound machine
MOB RENOVATIONS
Phone System
SFMG Vernon Suite 200-201
Ultrasound machine/Sports medicine

Reallocation to Johnson Memorial - part of strategic growth of RHM

EPICARE-JOHNSON MEMORIAL MEDICAL CENTER
JMMC KRONOS/FRONTIER IMPLEMENTAION
JMMC PeopleSoft

Saint Mary's Epic Implementation
Saint Mary's-Epic & Labor FY17
Saint Mary's-Hardware FY17
Saint Mary's-Third Party Software FY17
Capital leases associated with Epic and other
Asset Adjustments
RECLASS
Grand Total

(Multiple Items)
Sum of Amount
2,744,912
5,990
13,797
15,909
74,147
(115,528)
1,010,293
320
274
464,916
35,127
30,410
183,642
9,824
(6,783)
(229,286)
2,482
304,442
142,340
-
54,082
14,841
2,200
561,658
73,155
93,389
3,270
3,075,449
983,929
6,652
11,870
80,957
103,776
79,673
663
23,657
464,125
2,555
361
962,422
301,625
4,749
48,435
2,565,492

6,508
60,588
197,873
(34,318)
172,286
1,170,494
661,965
7,732
33,969
6,506
172,125
4,167
58,319
47,278
7,152,038
13,676
4,175
2,565
222,365
10,735
4,496
8,619
880,902
24,100
9,900
14,234
211,177
47,869
8,500
14,100
77,919
(4,910)
(47,515)
6,000
3,942
1,020
11,705
4,965
256
50,328
(15,338)
16,988
17,358
109,475
118,142
(2,213)
1,311

12,433
25,325
69,411
617,382
500
(143,687)
124,006
22,859
7,005
16,525
8,744
10,640
233,746
1,205
140,433
40,504
75,341
24,780
69,444
3,053
(118)
7,250
8,000
(270)
115,301
26,520
(180,322)
(188,950)
(305,081)
151,067
3,808
7,780
(28,816)
66,686
133
262
(15,922)
(35,403)
(9,326)
131,043
14,851
(6,461)
4,509
100,000
19,056
3,104
313,038

6,298
19,065
(13,306)
6,342
69,719
4,470
133,629
508,753
334,675
1,137
1,236,315
93,530
3,925
348,793
50,383
5,203
5,760
(1,382)
175,000
5,186
52,000
96,000
73,561
46,165
3,085
-
66,308
52,030
48,500
32,208
40,103
7,500
3,941
5,834
243,075
1,029,339
110,542
17,190
-
392,486
7,733
459,964
41,424
844,662
15,739
412,756
416,167

29,249,149
20,269,815
4,821,428
4,157,906
9,113,990
1,298,154
7,815,836
55,775,030

DESCRIPTION	DEPT	QUAN	CLASS	TYPE
ARCHITECTUAL/MEP	7980	1	BLDG IMP	NONMEDICAL
ECG MACHINES MAC5500	7800	1	MOVEABLE	MEDICAL
20 BEDSIDE MOMITORS, 29 BASE & ANTENNAS	6140	40	MOVEABLE	MEDICAL
PRINTER, 260 CONNEX 3D	8320	1	MOVEABLE	NONMEDICAL
VERIGENIE READER INSTRUMENT	7361	1	MOVEABLE	MEDICAL
ELECTRONIC MOP & 2 BATTERIES	8100	1	MOVEABLE	NONMEDICAL
ADDITIONAL STORAGE FOR CAMERAS	8350	1	MOVEABLE	NONMEDICAL
CAMERA	8350	19	MOVEABLE	NONMEDICAL
STERIS 3023	7850	1	MOVEABLE	MEDICAL
LAB TURNAROUND OUTLIER	7361	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 VARIABLE HEIGHT	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
IMAGE 1 S H 3-Z	7010	1	MOVEABLE	MEDICAL
ULTRASOUND 101912 EPIQ 5G	7290	1	MOVEABLE	MEDICAL
VSD OPTICVIEW MICROPANEL	8300	1	MOVEABLE	NONMEDICAL
VSD OPTICVIEW MICROPANEL	8300	1	MOVEABLE	NONMEDICAL
APPLICATION & CERTIFICATE	8300	1	FIXED	NONMEDICAL
APPLICATION & CERTIFICATE	7980	1	FIXED	NONMEDICAL
VISION ELECTRIC	7980	1	FIXED	NONMEDICAL
UNBNDLD 2 NODE GEN 4LP	7280	1	MOVEABLE	NONMEDICAL
DOUBLE SPINDLE LIGHTS OR5	7010	1	MOVEABLE	NONMEDICAL
DOUBLE SPINDLE LIGHTS OR5	7010	1	MOVEABLE	NONMEDICAL
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL
GAS CHARBOILER	8000	1	MOVEABLE	NONMEDICAL
FIRE PROTECTION PROJECT	8300	1	MOVEABLE	NONMEDICAL
EXHAUST FAN GARBAGE AREA	8300	1	MOVEABLE	NONMEDICAL
FIRE ALARM PANEL	8300	1	MOVEABLE	NONMEDICAL
SCOPE & MONITOR	7800	2	MOVEABLE	MEDICAL
APPLICATION & CERTIFICATE	7980	1	FIXED	NONMEDICAL
CHESHIRE PJT - CART	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT -TELEPHONE SYSTEM	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - FIBER INSTALL	7700	1	FIXED	NONMEDICAL
CHESHIRE PJT - SIGNS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - ARCHITECTURE	7700	1	BLDG IMP	NONMEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - CABINETS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - ARCHITECTURE	7700	1	BLDG IMP	NONMEDICAL
CHESHIRE PJT - CONSTRUCTION	7700	1	BLDG IMP	NONMEDICAL

CHESHIRE PJT - XRAY TESTING	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - COMPUTER	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - EQUIPMENT	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MASCOT	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - CHAIRS	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - WORKSTATION	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - MED EQUIPMENT	7700	1	MOVEABLE	MEDICAL
CHESHIRE PJT - FEE	7700	1	MOVEABLE	NONMEDICAL
CHESHIRE PJT - FURNITURE	7700	1	MOVEABLE	NONMEDICAL
CATH LAB PJT - EQUIPMENT	7460	1	MOVEABLE	MEDICAL
CATH LAB PJT - CONSTRUCTION	7460	1	BLDG IMP	NONMEDICAL
CATH LAB PJT - ARCHITECTURE	7460	1	BLDG IMP	NONMEDICAL
CATH LAB PJT - EQUIPMENT	7460	1	MOVEABLE	MEDICAL
CHESHIRE PJT -ANALYZER	7700	1	MOVEABLE	MEDICAL
ENDOSCOPE 0 DEG, 8 MM	7010	1	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
POSITIONER DEMAYO 30" BASE	7010	2	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
SURGICAL EQUIPMENT	7850	1	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
CART W ACCESSORIES	7570	10	MOVEABLE	MEDICAL
SHIMADZU MOBILE	7850	1	MOVEABLE	MEDICAL
SCOPE INTUBATION FLEX	7220	1	MOVEABLE	MEDICAL
HOPKINS II TELESCOPE	7010	4	MOVEABLE	MEDICAL
HOPKINS II TELESCOPE	7010		MOVEABLE	MEDICAL
TIE IN VULCAN SECURITY SYSTEM	8350	1	FIXED	NONMEDICAL
TENNANT/NOBLES T2 SCRUBBER	8100	1	MOVEABLE	NONMEDICAL
EXHAUST FAN OUTSIDE GARABE AREA	8300	1	MOVEABLE	NONMEDICAL
HYSTERSCOPE	7850	1	MOVEABLE	MEDICAL
HYSTERSCOPE	7850	1	MOVEABLE	MEDICAL
AVALON FM50 FETAL MONITOR	7070	14	MOVEABLE	MEDICAL
AVALON FM50 FETAL MONITOR	7070	14	MOVEABLE	MEDICAL
SCOPE INTUBATION FLEX VIDEO	7220	1	MOVEABLE	MEDICAL
FIRE PREVENTION PROJECT	8300	1	MOVEABLE	NONMEDICAL
ACUSON SC2000 ULTRASOUND SYSTEM	7440	1	MOVEABLE	MEDICAL
WORKSTATION	7540	1	MOVEABLE	NONMEDICAL
DEFIBRILATORS R SERIES	8320	2	MOVEABLE	MEDICAL
FIRE PREVENTION PJT SM COMPUTER RM	8300	1	MOVEABLE	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL
ROOF	8300	1	BLDG IMP	NONMEDICAL

REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	MOVEABLE	NONMEDICAL
MOTOROLA SL7550E RADIO	8350	20	MOVEABLE	NONMEDICAL
MOTOROLA SL7550E RADIO	8350	20	MOVEABLE	NONMEDICAL
APPLICATION AND CERTIFICATE	7980	1	FIXED	NONMEDICAL
WOUNDCARE RENOVATION	7550		BLDG IMP	NONMEDICAL
WOUNDCARE RENOVATION	7550		BLDG IMP	NONMEDICAL
PROFESSIONAL DESIGN	8300	0	MOVEABLE	NONMEDICAL
HEMATOLOGY ANALYZER XN SERIES	7361	1	MOVEABLE	MEDICAL
NEXUS SECURE TRANS MNGMT STATION	7361	1	MOVEABLE	NONMEDICAL
SERVING COUNTER & REGISTER STAND	8000	1	MOVEABLE	NONMEDICAL
CSI SYSTEMS UPGRADE	8300	1	MOVEABLE	NONMEDICAL
END OF LIFE PACS COMPUTERS	7280	1	MOVEABLE	MEDICAL
ROOF - CENTRAL PLANT	8300	1	BLDG IMP	NONMEDICAL
CHAIRS W/ ARMS	7280	12	MOVEABLE	NONMEDICAL
RENOVATIONS BLOOD DRAW	**7904**	**1**	**BLDG IMP**	**NONMEDICAL**
MICROSCOPE LENS & ACCESSORIES	7360	1	MOVEABLE	MEDICAL
MULTI DRIVE FRAME W/ HERCULES	6500	24	MOVEABLE	MEDICAL
MULTI DRIVE FRAME W/ HERCULES	6500	24	MOVEABLE	MEDICAL
DESIGNER JET PRINTER T2530	8300	1	MOVEABLE	NONMEDICAL
RECLINERS	3150	6	MOVEABLE	NONMEDICAL
RECLINERS	6200	4	MOVEABLE	NONMEDICAL
RECLINERS	3130	5	MOVEABLE	NONMEDICAL
RECLINERS	3320	3	MOVEABLE	NONMEDICAL
RECLINERS	3500	4	MOVEABLE	NONMEDICAL
RECLINERS	3140	2	MOVEABLE	NONMEDICAL
SPECTRUM IV PUMPS	8320	1	MOVEABLE	MEDICAL
SPECTRUM IV PUMPS	8320	1	MOVEABLE	MEDICAL
FLOORING/INSTALL	8300	1	FIXED	NONMEDICAL
STEAM GENERATOR	7850	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - TELEPHONE SYSTEM	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - PHARMACY FILTERS	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - COMPUTERS	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - CONSTRUCTION	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - ELECTRICAL	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - CABINET	7936	1	MOVEABLE	NONMEDICAL
ONCOLOGY PRJT - DATA LINES	7936	1	FIXED	NONMEDICAL
ONCOLOGY PRJT - CONSTRUCTION	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - ARCHITECTURE	7936	1	BLDG IMP	NONMEDICAL
ONCOLOGY PRJT - FURNITURE	7936	1	MOVEABLE	NONMEDICAL
WOUNDCARE PRJT - WALLS	7550	1	BLDG IMP	NONMEDICAL
WOUNDCARE PRJT - TV	7550	1	MOVEABLE	NONMEDICAL
RENOVATION - WATERTOWN BLOOD	**7904**	**1**	**BLDG IMP**	**NONMEDICAL**
RENOVATION - WOLCOTT UC	**7361**	**1**	**BLDG IMP**	**NONMEDICAL**
DATA LINES	7981	1	FIXED	NONMEDICAL
DATA LINES	7981	1	FIXED	NONMEDICAL

DATA LINES	7980	1	FIXED	NONMEDICAL
EXHAUST FAN - ANNEX CHILLER	8300	1	MOVEABLE	NONMEDICAL
TRANSDUCER/ MONITORS	7070	1	MOVEABLE	MEDICAL
CSI UPGRADE	8300	1	MOVEABLE	NONMEDICAL
OR INSTRUMENTS	7010	1	MOVEABLE	MEDICAL
RENoVATION WEST MAIN CARD	7901	1	BLDG IMP	NONMEDICAL
1981 E MAIN TENANTS WORK PAYOUT	7905	1	BLDG IMP	NONMEDICAL
MRI PRJT - BLDG IMP	7340	1	BLDG IMP	NONMEDICAL
MRI PRJT - FIXED	7340	1	FIXED	NONMEDICAL
MRI PRJT - LAND IMP	7340	1	LAND IMP	NONMEDICAL
MRI PRJT - MOVEABLE	7340	1	MOVEABLE	MEDICAL
ULTRASOUND 101912 EPIQ 5G	7290	1	MOVEABLE	MEDICAL
PARKING GARAGE DRAIN WORK	8300	1	BLDG IMP	NONMEDICAL
PARKING GARAGE DRAIN WORK	8300	1	BLDG IMP	NONMEDICAL
SIDEWALK AND WALL REPAIR	8300	1	BLDG IMP	NONMEDICAL
REPAIRS TO COLE STREET PARKING GARAGE	8300	1	BLDG IMP	NONMEDICAL
APPL AND CERT FOR PYMT FOR WEST MAIN CARDIO RENO\	8300	1	BLDG IMP	NONMEDICAL
ANALYE EMER POWER FOR GENERATOR ENG	8300	1	BUILD IMP	NONMEDICAL
PROF SRVS FOR ONCOLOGY PROJ LEEVER CTR PH 1 & 2 OF	7936	1	BUILD IMP	NONMEDICAL
REMOVE & INSTALL TRANSDUCER	8300	1	BUILD IMP	NONMEDICAL
AIR HANDLER REPLACEMT-NAUG UCC & PT	8300	1	FIXED	NONMEDICAL
AIR HANDLER REPLACEMT-NAUG UCC & PT	8300	1	FIXED	NONMEDICAL
SECURITY SYSTEM FOR ALL PATIENT AREAS	8350	1	FIXED	NONMEDICAL
SINK 120" TRIPLE BAY CLEANUP FIXED HT W/INSTALL	7570	1	FIXED	NONMEDICAL
ALPHA 7 SURGICAL ULTRASOUND SCANNER	7010	1	MOVEABLE	MEDICAL
BESIDE MONITOR SH3	6140	1	MOVEABLE	MEDICAL
FORCEPOINT V10K	9080	1	MOVEABLE	NONMEDICAL
TEST CARDINAL SERUM/URINE HCG RAPID	7905	1	MOVEABLE	MEDICAL
TRAINING MTRL-GUNSHOT WOUND BICEP W/SHIPPING	7800	1	MOVEABLE	MEDICAL
TRAINING MTRL-LEG AMPUTATION	7800	1	MOVEABLE	MEDICAL
TRAINING MTRL-GSW TO LEG	7800	1	MOVEABLE	MEDICAL
TACTICAL TRAINING MATERIALS	7800	1	MOVEABLE	MEDICAL
TABLE OVERBED ART CARE OAK AND BRIO BEDSIDE CABINI	8100	24	MOVEABLE	NONMEDICAL
SPEEDCHCK SOFTWARE & TOUCHSCREEN TERM FOR CASH	5800	1	MOVEABLE	NONMEDICAL
MICROSCOPE FRAME BX43F W/CLOTH ANTISTATIC DUSTCO	7360	1	MOVEABLE	MEDICAL
ROTATABLE NOSEPIECE U-RE 2.5 POS	7360	1	MOVEABLE	MEDICAL
BINOC OBSERV TUBE U-B130-2-2	7360	1	MOVEABLE	MEDICAL
RT HAND MECH STAGE RACKLESS, LONG W/LEFT RELEASE	7360	1	MOVEABLE	MEDICAL
VIDEO URETERO-RENOSCOPE FLEX-XC	7010	1	MOVEABLE	MEDICAL
8 FT OVAL CONF TABLE, NESTING SIDE CHAIRS, DESK & BLA	8300	1	MOVEABLE	NONMEDICAL
INSIGHT FD MINI C-ARM	7010	1	MOVEABLE	MEDICAL
VITRE EXTEND BASIC PACKAGE	7280	1	MOVEABLE	MEDICAL
SHIMADZU MOBILE MX7C W/SINGLE PANEL	7850	1	MOVEABLE	MEDICAL
SLEEP CHAIR	7070	10	MOVEABLE	NONMEDICAL
LABOR AND MTLS TO INSTALL WALL HUNG P SERIES MITSU	8300	1	FIXED	NON-MEDICAL
DISHWASHER-HOBART	8000	1	FIXED	NON-MEDICAL
HOSPITAL DOOR RELEASE	8300	1	FIXED	NON-MEDICAL

LABOR FOR CLEANING AREA & FURNITURE WATER DAMAGE	8300	1	FIXED	NON-MEDICAL
LAB & MAT 3801 E MAIN ST COUNTERTOP RT TO SINK	8300	1	FIXED	NON-MEDICAL
LAB & MAT INSTALL SECURITY SYSTEM ALL PT AREAS	8300	1	FIXED	NON-MEDICAL
LEEVER CT RENOVATIONS PHASE 2	8300	1	FIXED	NON-MEDICAL
GENERAL CONDITIONS, DRYWALL, FLOORING, ETC KITCHEN	8300	1	FIXED	NON-MEDICAL
LABOR MATERIALS EQUIPMENT CHAPLIN AREA	9180	1	FIXED	NON-MEDICAL
LABOR MATERIALS EQUIPMENT SECURITY PROJECT	8300	1	FIXED	NON-MEDICAL
FREIGHT IV PUMPS	8320	1	MOVEABLE	MEDICAL
PRIME BLADDER SCANNER W/ CART	7800	2	MOVEABLE	MEDICAL
LIGHT HANDLE CAMERA COVER	7010	1	MOVEABLE	MEDICAL
OVERBEDTABLE MAPLE	6500	24	MOVEABLE	NON-MEDICAL
HYDRASLIM SINGLEPORT SYSTEM	7800	2	MOVEABLE	MEDICAL
SMALL BLOOD POWER	7800	1	MOVEABLE	MEDICAL
AVALON FETAL MONITORS	7070	15	MOVEABLE	MEDICAL
REPROCESSOR ENDOSCOPE	7850	3	MOVEABLE	MEDICAL
COLONSCOPE W/DUAL FOCUS	7850	2	MOVEABLE	MEDICAL
VITRE EXTENDS BASIC	7280	1	MOVEABLE	MEDICAL
ADULT WATER RESCUE MANAKIN	7800	1	MOVEABLE	MEDICAL
FLS ALL IN ONE TRAINER SYSTEM	7881	1	MOVEABLE	MEDICAL
NEXUS SECURE TRANSACTION MGMT	7361	1	MOVEABLE	MEDICAL
VIDEO URETERO RENOSCOPE	7010	1	MOVEABLE	MEDICAL
PAVEMENT MARKING GARGAGE/ER-VALET-LOTS	8300	1	LAND IMP	NON-MEDICAL
MRI PROJECT #15-002 BLDG IMPR	7340	1	BLDG IMPR	NON-MEDICAL
E. MAIN PROJ #17-003 LEASEHOLD IMP	7905	1	BLDG IMPR	NON-MEDICAL
EPIC PROJ. BLDG IMPR	9080	1	BLDG IMPR	NON-MEDICAL
APPL& CERT. FOR LEEVER CLEAN RM	8300	1	FIXED	NON-MEDICAL
LABOR/MATERIAL HR-PAYROLL RENOVATIONS	8300	1	FIXED	NON-MEDICAL
E. MAIN PROJ #17-003 FIXED EQUIP.	7905	1	FIXED	NON-MEDICAL
EPIC PROJ. CAPITAL LABOR	9080	1	FIXED	NON-MEDICAL
TRANMISSION FOR HOSP TRUCK	7809	1	AUTO	NON-MEDICAL
OVERBED TABLE	6500	1	MOVEABLE	NON-MEDICAL
VIDEO URETERO RENOSCOPE	7010	1	MOVEABLE	MEDICAL
REMOVE/INSTALL STERILIZER/BOILER	7835	1	MOVEABLE	MEDICAL
INST. INTERFACE VAI SQ INST MGMT	7936	1	MOVEABLE	MEDICAL
TELESCOPE HOPKINS 11 0	7010	1	MOVEABLE	MEDICAL
NETWORK UPGRADES PROCESSBY TRINITY	9080	1	MOVEABLE	NON-MEDICAL
MRI PROJ #15-002 FURNITURE/OFFICE EQUIPMENT	7340	1	MOVEABLE	NON-MEDICAL
E. MAIN PROJ #17-003 COMPUTERS	7905	1	MOVEABLE	NON-MEDICAL
E. MAIN PROJ $17-003 FURNITURE/OFFICE EQUIP	7905	1	MOVEABLE	NON-MEDICAL
EPIC PROJ. COMPUTER EQUIP	9080	1	MOVEABLE	NON-MEDICAL
EPIC PROJ FURNITURE/OFFICE EQUIP	9080	1	MOVEABLE	NON-MEDICAL

Regular Additions
CIP Additions
TOTAL

ACQ DATE	ENTRY PER	LOCATION	AMT	VENDOR	PO
4/30/2017	07/2017	SLEEP LAB	970.00	MOSER	1709807
4/30/2017	07/2017	EMER	11,369.82	GE - 17858	1709089
4/30/2017	07/2017	TELEMETRY	578,971.45	PHILIPS - 18801	1706061
4/30/2017	07/2017	CLINICAL ENG	24,730.00	STRATASYS	1709090
4/30/2017	07/2017	MICRO LAB	55,000.00	NANOSPHERE	1709971
4/30/2017	07/2017	ENVIRON	4,850.00	MEDLINE	1710344
4/30/2017	07/2017	SECURITY	15,800.00	STERLING	1707442
4/30/2017	07/2017	SECURITY	29,077.00	STERLING	1705797
4/30/2017	07/2017	NVSC	12,211.30	MEDIQUIP	1710192
4/30/2017	07/2017	LAB	3,305.00	SUNQUEST	1705251
4/30/2017	07/2017	OR	378,845.27	KARL STORZ	1709660
4/30/2017	07/2017	OR	4,425.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	31,050.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	10,350.00	KARL STORZ	1709660
4/30/2017	07/2017	OR	(931.50)	KARL STORZ	1709660
4/30/2017	07/2017	OR	(11,646.61)	KARL STORZ	1709660
4/30/2017	07/2017	OR	27,929.02	KARL STORZ	1709660
4/30/2017	07/2017	OR	(132.75)	KARL STORZ	1709660
4/30/2017	07/2017	ULTRASOUND	120,261.30	PHILIPS - 18801	1706888
4/30/2017	07/2017	PLANT	91,390.00	JOHNSON CONTROLS	1706358
4/30/2017	07/2017	PLANT	(71,307.00)	JOHNSON CONTROLS	1706358
4/30/2017	07/2017	PLANT	88,098.61	O and G	1709019
4/30/2017	07/2017	SLEEP LAB	62,369.98	O and G	1709021
4/30/2017	07/2017	SLEEP LAB	9,172.00	O and G	1709173
4/30/2017	07/2017	RAD	24,245.90	CDW	1707678
4/30/2017	07/2017	OR	13,419.87	STERIS	1710054
4/30/2017	07/2017	OR	(3,022.97)	STERIS	1710054
4/30/2017	07/2017	FOOD	7,226.34	PERFORMANCE INT	1705599
4/30/2017	07/2017	FOOD	(29.81)	PERFORMANCE INT	1705599
4/30/2017	07/2017	PLANT	80,757.00	NEWMACK	1618556
4/30/2017	07/2017	PLANT	2,099.00	GOOD HILL	1710034
4/30/2017	07/2017	PLANT	1,820.00	CPE ELECTRIC	1705421
4/30/2017	07/2017	ED	4,590.88	TRI ANIM	1711247
4/30/2017	07/2017	SLEEP LAB	28,108.98	O and G	1709023
5/31/2017	08/2017	CHESHIRE UC	5,740.00	ARMSTRONG	1618392
5/31/2017	08/2017	CHESHIRE UC	234,166.26	ATRION NETWRKING	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	391.00	BURLINGTON MED	1614339
5/31/2017	08/2017	CHESHIRE UC	5,046.52	CARDINAL	1614845
5/31/2017	08/2017	CHESHIRE UC	1,952.10	CDW	16130.5
5/31/2017	08/2017	CHESHIRE UC	750.00	CHIMENET	NA
5/31/2017	08/2017	CHESHIRE UC	12,615.00	CONNECTICUT SIGNCRA	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	83,427.03	CROSSKEY	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	42,450.55	DELL MARKETING	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	14,300.00	DISPLAY WRIGHT	1708807
5/31/2017	08/2017	CHESHIRE UC	36,700.75	FLETCHER THOMPSON	NA
5/31/2017	08/2017	CHESHIRE UC	1,253,371.76	FORTUNATO CONSTRUC	VARIOS

5/31/2017	08/2017	CHESHIRE UC	1,200.00	GJ RANDALL MS	NA
5/31/2017	08/2017	CHESHIRE UC	13,162.85	GOV CONNECTION	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	344.32	GRAINGER	1618393
5/31/2017	08/2017	CHESHIRE UC	5,304.00	LANDMARK	NA
5/31/2017	08/2017	CHESHIRE UC	1,457.00	MARKETLAB	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	25,507.91	MCKESSON	1614881
5/31/2017	08/2017	CHESHIRE UC	20,004.02	MERGE HEALTHCARE	1614354
5/31/2017	08/2017	CHESHIRE UC	103,492.00	PARKER- XRAY	VARIOUS
5/31/2017	08/2017	CHESHIRE UC	575.00	STATE OF CT	NA
5/31/2017	08/2017	CHESHIRE UC	30,235.82	WB MASON	VARIOUS
5/31/2017	08/2017	CATH LAB	14,376.53	CAROUSEL IND	1611912
5/31/2017	08/2017	CATH LAB	74,399.26	O AND G	VARIOUS
5/31/2017	08/2017	CATH LAB	24,835.39	MOSER PILON	VARIOUS
5/31/2017	08/2017	CATH LAB	577,188.00	SIEMENS	1609980
5/31/2017	08/2017	CHESHIRE UC	15,888.00	ABBOT LAB	1615143
5/31/2017	08/2017	SURGERY	9,000.00	INTUITIVE SURGICAL	1711486
5/31/2017	08/2017	OR	295.92	STERIS	1707248
5/31/2017	08/2017	OR	(174.59)	STERIS	1707248
5/31/2017	08/2017	OR	12,040.00	INNOVATION	1711440
5/31/2017	8/2017	NVSC	7,590.00	ARTHREX	1711438
5/31/2017	8/2017	NVSC	37,216.00	ARTHREX	1711438
5/31/2017	8/2017	NVSC	1,130.00	ARTHREX	1711438
12/31/2016	03/2017	CENTRAL STER	24,771.80	CARDINAL	1704227
12/31/2016	03/2017	CENTRAL STER	(42,284.30)	CARDINAL HEALTH	1704227
12/31/2016	03/2017	CENTRAL STER	18,685.30	CARDINAL	1704227
5/31/2017	08/2017	NVSC	14,300.00	MEDICAL IMAGING	1711740
5/31/2017	08/2017	ANES	6,840.00	KARL STORZ	1711770
5/31/2017	08/2017	SURGERY	29,564.20	KARL STORZ	1711630
5/31/2017	08/2017	SURGERY	(837.90)	KARL STORZ	1711630
5/31/2017	8/2017	SECURITY	14,960.00	TPC	1711728
5/31/2017	08/2017	ENVIRONMENTAL	4,116.87	GRAINGER	1710338
5/31/2017	08/2017	PLANT	2,099.00	GOOD HILL	1710034
5/31/2017	08/2017	NVSC	35,678.00	HOLOGIC	1711431
5/31/2017	08/2017	NVSC	(11,064.79)	HOLOGIC	1711431
5/31/2017	08/2017	LABOR AND DELIVERY	66,891.40	PHILIPS 18801	1707758
5/31/2017	08/2017	LABOR AND DELIVERY	138,284.10	PHILIPS 18801	1707758
5/31/2017	08/2017	ANES	6,840.00	KARL STORZ	1712318
5/31/2017	08/2017	PLANT	63,563.00	NEWMACK	1619956
5/31/2017	08/2017	ELETRO CARDO	216,872.00	SIEMENS 20981	1710047
5/31/2017	08/2017	CCU	5,106.00	DRAEGER	1614693
5/31/2017	08/2017	CLINICL	28,853.00	ZOLL	1707444
5/31/2017	08/2017	PLANT	24,567.00	NEWMACK	1619957
5/31/2017	08/2017	PLANT	16,000.00	HERITAGE	1711844
5/31/2017	08/2017	PLANT	44,950.00	HERITAGE	1702785
5/31/2017	08/2017	PLANT	(13,485.00)	HERITAGE	1702785
5/31/2017	08/2017	PLANT	14,000.00	HERITAGE	1711838
5/31/2017	08/2017	PLANT	(2,800.00)	HERITAGE	1711838

5/31/2017	08/2017	PLANT	(33,710.47)	JOHNSON CONTROL	1706358
5/31/2017	08/2017	PLANT	33,710.47	JOHNSON CONTROL	1706358
5/31/2017	08/2017	PLANT	23,969.06	JOHNSON CONTROL	1706358
5/31/2017	08/207	SECURITY	22,834.20	NORTHEASTERN COMM	1705583
5/31/2017	08/207	SECURITY	1,105.00	NORTHEASTERN COMM	1705583
4/30/2017	07/2017	SLEEP LAB	14,043.49	O AND G	1711475
5/31/2017	08/2017	PLANT	49,750.00	O AND G	1705373
5/31/2017	08/2017	PLANT	10,985.00	O AND G	1705373
12/31/2016	03/2017	PLANT	(1,400.00)	MILONE	1620105
6/30/2017	09/2017	LAB	147,918.00	SYSMEX AMER	1710210
6/30/2017	09/2017	LAB	179,499.25	TRANSLOGIC CORP	1705886
6/30/2017	09/2017	FOOD	14,674.81	WAREHOUSE STORE FIX	1710049
6/30/2017	09/2017	PLANT	49,700.00	SIEMENS IND	1711346
6/30/2017	09/2017	RAD	107,297.99	MERGE HEALTHCARE	1711779
6/30/2017	09/2017	PLANT	13,485.00	HERITAGE	1702785
6/30/2017	09/2017	RAD	5,062.56	WB MASON	1709423
6/30/2017	**09/2017**	**WOLCOTT UC**	**38,215.40**	**CLASSIC BLDRS**	**1714251**
6/30/2017	09/2017	MICRO LAB	3,015.61	OLYMPUS 16331	1714056
6/30/2017	09/2017	CCU	662,028.76	LINET AMERICAS	1711273
6/30/2017	09/2017	CCU	(3,840.00)	LINET AMERICAS	1711273
6/30/2017	09/2017	PLANT	9,150.00	WB MASON	1714384
6/30/2017	09/2017	OB4	9,799.92	WB MASON	1710438
6/30/2017	09/2017	OB7	6,205.64	WB MASON	1710438
6/30/2017	09/2017	SH5	7,762.05	WB MASON	1710438
6/30/2017	09/2017	X3	4,654.23	WB MASON	1710438
6/30/2017	09/2017	CCU	6,201.64	WB MASON	1710438
6/30/2017	09/2017	TELE	3,101.70	WB MASON	1710438
6/30/2017	09/2017	CLINICAL	3,750.00	BAXTER	1713941
6/30/2017	09/2017	CLINICAL	92,500.00	BAXTER	1713941
6/30/2017	09/2017	PLANT	16,459.34	WB MASON	1608995BL
6/30/2017	09/2017	NVSC	12,211.30	MEDIQUIP	1710192
6/30/2017	09/2017	ONCOLOGY	52,227.60	ATRION NETWORKING	1617300
6/30/2017	09/2017	ONCOLOGY	4,730.00	BUCKLEY	1702117
6/30/2017	09/2017	ONCOLOGY	44,282.41	CDW COMPUTERS	1703192/01
6/30/2017	09/2017	ONCOLOGY	2,300.00	ENGINEERED	NA
6/30/2017	09/2017	ONCOLOGY	36,415.00	GOOD HILL	1611146
6/30/2017	09/2017	ONCOLOGY	24,972.00	LM AIR TECH	1610246
6/30/2017	09/2017	ONCOLOGY	19,615.79	MID-STATE TELEDATA	1702426
6/30/2017	09/2017	ONCOLOGY	987,316.63	STANDARD BUILDERS	VARIOUS
6/30/2017	09/2017	ONCOLOGY	134,841.11	TECTON ARCH	VARIOUS
6/30/2017	09/2017	ONCOLOGY	77,485.60	WB MASON	1616845
6/30/2017	09/2017	WOUNDCARE	6,273.90	INPRO CORPORATION	1706596
6/30/2017	09/2017	WOUNDCARE	850.25	TELEHEALTH	1710200
6/30/2017	**09/2017**	**WATERTOWN BLOOD**	**18,092.90**	**CLASSIC BLDRS**	**1714251**
6/30/2017	**09/2017**	**WOLCOTT UC**	**20,122.50**	**CLASSIC BLDRS**	**1714251**
6/30/2017	09/2017	SLEEP WOLCOTT	1,360.00	MID-STATE TELEDATA	1707588
6/30/2017	09/2017	SLEEP WOLCOTT	625.00	MID-STATE TELEDATA	1707588

6/30/2017	09/2017		SLEEP WTBY	615.00	MID-STATE TELEDATA	1707588
6/30/2017	09/2017		PLANT	41,077.00	SARRACCO	1713007
6/30/2017	09/2017		WIC	3,154.04	PHILIPS - 18801	1707758
6/30/2017	09/2017		PLANT	52,800.00	SIEMENS IND	1711346
6/30/2017	09/2017		OR	20,394.00	SOLOS END	1712323
6/30/2017	09/2017		CARDIO	98,752.50	BISMARCK	1715305
6/30/2017	09/2017		EAST MAIN	704,062.18	YAMIN & GRANT LLC	NA
6/30/2017	09/2017		MRI	4,796,329.63	VARIOUS	VARIOUS
6/30/2017	09/2017		MRI	33,066.00	MID-STATE TELEDATA	1701701
6/30/2017	09/2017		MRI	23,765.50	ALL LAWN CARE	VARIOUS
6/30/2017	09/2017		MRI	764,167.16	TELEHEALTH	VARIOUS
4/30/2017	07/2017		ULTRASOUND	(112,861.30)	PHILIPS - 18801	1706888
42947		10	PLANT	7,200.00	JOHN'S ASPHALT	1713175
42947		10	PLANT	16,300.00	JOHN'S ASPHALT	1713265
42947		10	PLANT	69,500.00	JOHN'S ASPHALT	1715631
42947		10	PLANT	34,759.00	BISMARCK	1713189
42947		10	PLANT	115,955.00	BISMARCK	1715627
42947		10	PLANT	118,850.00	SODEXHO	1715617
42947		10	ONCOLOGY	2,793.86	TECTON ARCHITECTS	1611961
42947		10	PLANT	13,627.47	JOHNSON CONTROL	1706358
42947		10	PLANT	14,250.00	GOODHILL	1715038
42947		10	PLANT	14,250.00	GOODHILL	1715038
42947		10	SECURITY	229,927.14	VULCAN SECURITY	1711726
42947		10	CENTRAL STERILE	15,357.85	STERIS	1711433
42947		10	SURG UNIT	151,922.75	HITACHI	1716221
42947		10	TELEMETRY	(5,391.88)	PHILIPS	1706061
42947		10	IT	17,091.00	K LOGIC	1715123
42947		10	EAST MAIN-UCC	23.19	CARDINAL	1715563
42947		10	EMER RM	1,697.00	TECHLINE	1714730
42947		10	EMER RM	888.25	TECHLINE	1714730
42947		10	EMER RM	516.38	TECHLINE	1714730
42947		10	EMER RM	6,444.67	NORTH AMERICAN	1714870
42947		10	ENVIROMENT	18,011.52	HILL ROM	1710342
42947		10	CAFÉ	5,819.85	NCR OF NEW ENGLAND	1710053
42947		10	LAB	1,172.76	OLYMPUS AMER	1714056
42947		10	LAB	347.13	OLYMPUS AMER	1714056
42947		10	LAB	834.33	OLYMPUS AMER	1714056
42947		10	LAB	476.76	OLYMPUS AMER	1714056
42947		10	SURG UNIT	3,952.55	KARL STORZ	1714095
42947		10	PLANT	4,131.00	HUDSON VALLEY OFFCIE FU	1715616
42947		10	SURG UNIT	69,500.00	HOLOGIC	1715256
42947		10	RADIOLOGY	72,155.20	TOSHIBA	1709559
42947		10	NVSC	128,700.00	MEDICAL IMAGING	1711740
42947		10	LABOR & DELIVERY	14,892.60	WB MASON	1711397
08/31/2017		11	FACILITIES	9,676.00	SARRACCO	1714588
08/31/2017		11	CAFÉ	74,568.74	SODEXCO	1706461
08/31/2017		11	FACILITIES	15,609.00	SIMPLEX	1711729

08/31/2017	11	FACILITIES	750.00	CHAMPION	1717634
08/31/2017	11	FACILITIES	1,015.00	CHAMPION	1716633
08/31/2017	11	FACILITIES	11,346.82	VULCAN	1711726
08/31/2017	11	FACILITIES	167.50	TECTON	1611923
08/31/2017	11	FACILITIES	47,226.00	O AND G	1714580
08/31/2017	11	CHAPLIN	49,114.89	O AND G	1714083
08/31/2017	11	FACILITIES	12,609.90	O AND G	1715220
08/31/2017	11	CLINCIAL ENG	96.00	BAXTER	1713941
08/31/2017	11	EMER DEPT	22,000.00	VERATHON	1715989
08/31/2017	11	SURG UNIT	121.33	STERIS	1716725
08/31/2017	11	CCU	11,709.60	LINET AM	1714323
08/31/2017	11	EMER DEPT	5,951.41	TECHLINE	1714730
08/31/2017	11	EMER DEPT	114.00	TECHLINE	1714730
08/31/2017	11	WIC	8,219.00	PHILLIPS	1707758
08/31/2017	11	NVSC	90,632.07	OLYMPUS	1714665
08/31/2017	11	NVSC	173,915.14	OLYMPUS	1714662
08/31/2017	11	RADIOLOGY	18,038.80	TOSHBIA	1709559
08/31/2017	11	EMER DEPT	639.00	ALLIED 100	1714734
08/31/2017	11	SURG REG	13,263.52	LIMBS & THINGS	1716127
08/31/2017	11	LAB SENT OUT	30,355.25	TRANSLOGIC	1705886
08/31/2017	11	SURG UNIT	9,994.95	KARL STORZ	1718078
09/30/2017	12	PLANT	7,250.00	ARROW LINE PAINTING	1713176
09/30/2017	12	MRI	140,254.87	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	2,413,153.43	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	794,393.95	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	PLANT	39,347.74	STANDARD BUILDING	1718598
09/30/2017	12	PLANT	24,640.00	CHAMPION	1715306
09/30/2017	12	E MAIN CTR	126,685.32	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	11,659,632.71	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	STOREROOM	2,750.00	BLASIUS	N/A
09/30/2017	11	PLANT	(597.60)	LINET	1714323
08/31/2017	11	SURG UNIT	(5,054.85)	KARL STORZ	1718078
09/30/2017	12	NVSC	10,950.00	DESCO	1716033
09/30/2017	12	BOWEN	7,875.00	SUNQUEST	1712255
09/30/2017	12	SURG UNIT	12,084.00	KARL STORZ	1711630
09/30/2017	12	IT	886,766.10	TRINITY	N/A
09/30/2017	12	MRI	52,359.64	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	16,217.50	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	E MAIN CTR	175,317.45	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	13,844,831.76	VARIOUS-SEE NOTES	SEE NOTES
09/30/2017	12	IT	63,613.15	VARIOUS-SEE NOTES	SEE NOTES

$ 46,400,352.98
$ (9,841,443.79)
$ 36,558,909.19

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120	Sep-17

Explanation

1 new ARCHITECTUAL/MEP
1 new ECG MACHINES MAC5500
40 new 20 BEDSIDE MOMITORS, 29 BASE & ANTENNAS
1 new PRINTER, 260 CONNEX 3D
1 new VERIGENIE READER INSTRUMENT
1 new ELECTRONIC MOP & 2 BATTERIES
1 new ADDITIONAL STORAGE FOR CAMERAS
19 new CAMERA
1 new STERIS 3023
1 new LAB TURNAROUND OUTLIER
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 VARIABLE HEIGHT
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new IMAGE 1 S H 3-Z
1 new ULTRASOUND 101912 EPIQ 5G
1 new VSD OPTICVIEW MICROPANEL
1 new VSD OPTICVIEW MICROPANEL
1 new APPLICATION & CERTIFICATE
1 new APPLICATION & CERTIFICATE
1 new VISION ELECTRIC
1 new UNBNDLD 2 NODE GEN 4LP
1 new DOUBLE SPINDLE LIGHTS OR5
1 new DOUBLE SPINDLE LIGHTS OR5
1 new GAS CHARBOILER
1 new GAS CHARBOILER
1 new FIRE PROTECTION PROJECT
1 new EXHAUST FAN GARBAGE AREA
1 new FIRE ALARM PANEL
2 new SCOPE & MONITOR
1 new APPLICATION & CERTIFICATE
1 new CHESHIRE PJT - CART
1 new CHESHIRE PJT -TELEPHONE SYSTEM
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - FIBER INSTALL
1 new CHESHIRE PJT - SIGNS
1 new CHESHIRE PJT - ARCHITECTURE
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - CABINETS
1 new CHESHIRE PJT - ARCHITECTURE
1 new CHESHIRE PJT - CONSTRUCTION

1 new CHESHIRE PJT - XRAY TESTING
1 new CHESHIRE PJT - COMPUTER
1 new CHESHIRE PJT - EQUIPMENT
1 new CHESHIRE PJT - MASCOT
1 new CHESHIRE PJT - CHAIRS
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - WORKSTATION
1 new CHESHIRE PJT - MED EQUIPMENT
1 new CHESHIRE PJT - FEE
1 new CHESHIRE PJT - FURNITURE
1 new CATH LAB PJT - EQUIPMENT
1 new CATH LAB PJT - CONSTRUCTION
1 new CATH LAB PJT - ARCHITECTURE
1 new CATH LAB PJT - EQUIPMENT
1 new CHESHIRE PJT -ANALYZER
1 new ENDOSCOPE 0 DEG, 8 MM
1 new LIGHT HANDLE CAMERA COVER
1 new LIGHT HANDLE CAMERA COVER
2 new POSITIONER DEMAYO 30" BASE
1 new SURGICAL EQUIPMENT
1 new SURGICAL EQUIPMENT
1 new SURGICAL EQUIPMENT
10 new CART W ACCESSORIES
10 new CART W ACCESSORIES
10 new CART W ACCESSORIES
1 new SHIMADZU MOBILE
1 new SCOPE INTUBATION FLEX
4 new HOPKINS II TELESCOPE
new HOPKINS II TELESCOPE
1 new TIE IN VULCAN SECURITY SYSTEM
1 new TENNANT/NOBLES T2 SCRUBBER
1 new EXHAUST FAN OUTSIDE GARABE AREA
1 new HYSTERSCOPE
1 new HYSTERSCOPE
14 new AVALON FM50 FETAL MONITOR
14 new AVALON FM50 FETAL MONITOR
1 new SCOPE INTUBATION FLEX VIDEO
1 new FIRE PREVENTION PROJECT
1 new ACUSON SC2000 ULTRASOUND SYSTEM
1 new WORKSTATION
2 new DEFIBRILATORS R SERIES
1 new FIRE PREVENTION PJT SM COMPUTER RM
1 new ROOF
1 new ROOF - CENTRAL PLANT
1 new ROOF - CENTRAL PLANT
1 new ROOF
1 new ROOF

1 new REMOVE & INSTALL TRANSDUCER
1 new REMOVE & INSTALL TRANSDUCER
1 new REMOVE & INSTALL TRANSDUCER
20 new MOTOROLA SL7550E RADIO
20 new MOTOROLA SL7550E RADIO
1 new APPLICATION AND CERTIFICATE
new WOUNDCARE RENOVATION
new WOUNDCARE RENOVATION
0 new PROFESSIONAL DESIGN
1 new HEMATOLOGY ANALYZER XN SERIES
1 new NEXUS SECURE TRANS MNGMT STATION
1 new SERVING COUNTER & REGISTER STAND
1 new CSI SYSTEMS UPGRADE
1 new END OF LIFE PACS COMPUTERS
1 new ROOF - CENTRAL PLANT
12 new CHAIRS W/ ARMS
1 new RENOVATIONS BLOOD DRAW
1 new MICROSCOPE LENS & ACCESSORIES
24 new MULTI DRIVE FRAME W/ HERCULES
24 new MULTI DRIVE FRAME W/ HERCULES
1 new DESIGNER JET PRINTER T2530
6 new RECLINERS
4 new RECLINERS
5 new RECLINERS
3 new RECLINERS
4 new RECLINERS
2 new RECLINERS
1 new SPECTRUM IV PUMPS
1 new SPECTRUM IV PUMPS
1 new FLOORING/INSTALL
1 new STEAM GENERATOR
1 new ONCOLOGY PRJT - TELEPHONE SYSTEM
1 new ONCOLOGY PRJT - PHARMACY FILTERS
1 new ONCOLOGY PRJT - COMPUTERS
1 new ONCOLOGY PRJT - CONSTRUCTION
1 new ONCOLOGY PRJT - ELECTRICAL
1 new ONCOLOGY PRJT - CABINET
1 new ONCOLOGY PRJT - DATA LINES
1 new ONCOLOGY PRJT - CONSTRUCTION
1 new ONCOLOGY PRJT - ARCHITECTURE
1 new ONCOLOGY PRJT - FURNITURE
1 new WOUNDCARE PRJT - WALLS
1 new WOUNDCARE PRJT - TV
1 new RENOVATION - WATERTOWN BLOOD
1 new RENOVATION - WOLCOTT UC
1 new DATA LINES
1 new DATA LINES

1 new DATA LINES
1 new EXHAUST FAN - ANNEX CHILLER
1 new TRANSDUCER/ MONITORS
1 new CSI UPGRADE
1 new OR INSTRUMENTS
1 new RENoVATION WEST MAIN CARD
1 new 1981 E MAIN TENANTS WORK PAYOUT
1 new MRI PRJT - BLDG IMP
1 new MRI PRJT - FIXED
1 new MRI PRJT - LAND IMP
1 new MRI PRJT - MOVEABLE
1 new ULTRASOUND 101912 EPIQ 5G
1 new PARKING GARAGE DRAIN WORK
1 new PARKING GARAGE DRAIN WORK
1 new SIDEWALK AND WALL REPAIR
1 new REPAIRS TO COLE STREET PARKING GARAGE
1 new APPL AND CERT FOR PYMT FOR WEST MAIN CARDIO RENOV
1 new ANALYE EMER POWER FOR GENERATOR ENG
1 new PROF SRVS FOR ONCOLOGY PROJ LEEVER CTR PH 1 & 2 OPM
1 new REMOVE & INSTALL TRANSDUCER
1 new AIR HANDLER REPLACEMT-NAUG UCC & PT
1 new AIR HANDLER REPLACEMT-NAUG UCC & PT
1 new SECURITY SYSTEM FOR ALL PATIENT AREAS
1 new SINK 120" TRIPLE BAY CLEANUP FIXED HT W/INSTALL
1 new ALPHA 7 SURGICAL ULTRASOUND SCANNER
1 new BESIDE MONITOR SH3
1 new FORCEPOINT V10K
1 new TEST CARDINAL SERUM/URINE HCG RAPID
1 new TRAINING MTRL-GUNSHOT WOUND BICEP W/SHIPPING
1 new TRAINING MTRL-LEG AMPUTATION
1 new TRAINING MTRL-GSW TO LEG
1 new TACTICAL TRAINING MATERIALS
24 new TABLE OVERBED ART CARE OAK AND BRIO BEDSIDE CABINETS
1 new SPEEDCHCK SOFTWARE & TOUCHSCREEN TERM FOR CASH REGISTERS
1 new MICROSCOPE FRAME BX43F W/CLOTH ANTISTATIC DUSTCOVER & POWERCORD
1 new ROTATABLE NOSEPIECE U-RE 2.5 POS
1 new BINOC OBSERV TUBE U-B130-2-2
1 new RT HAND MECH STAGE RACKLESS, LONG W/LEFT RELEASE HOLDER
1 new VIDEO URETERO-RENOSCOPE FLEX-XC
1 new 8 FT OVAL CONF TABLE, NESTING SIDE CHAIRS, DESK & BLACK MESH CONF CHAIRS
1 new INSIGHT FD MINI C-ARM
1 new VITRE EXTEND BASIC PACKAGE
1 new SHIMADZU MOBILE MX7C W/SINGLE PANEL
10 new SLEEP CHAIR
1 new LABOR AND MTLS TO INSTALL WALL HUNG P SERIES MITSUBISHI COOLING FOR 8TH FL IT CLOSET
1 new DISHWASHER-HOBART
1 new HOSPITAL DOOR RELEASE

1 new LABOR FOR CLEANING AREA & FURNITURE WATER DAMAGE
1 new LAB & MAT 3801 E MAIN ST COUNTERTOP RT TO SINK
1 new LAB & MAT INSTALL SECURITY SYSTEM ALL PT AREAS
1 new LEEVER CT RENOVATIONS PHASE 2
1 new GENERAL CONDITIONS, DRYWALL, FLOORING, ETC KITCHEN
1 new LABOR MATERIALS EQUIPMENT CHAPLIN AREA
1 new LABOR MATERIALS EQUIPMENT SECURITY PROJECT
1 new FREIGHT IV PUMPS
2 new PRIME BLADDER SCANNER W/ CART
1 new LIGHT HANDLE CAMERA COVER
24 new OVERBEDTABLE MAPLE
2 new HYDRASLIM SINGLEPORT SYSTEM
1 new SMALL BLOOD POWER
15 new AVALON FETAL MONITORS
3 new REPROCESSOR ENDOSCOPE
2 new COLONSCOPE W/DUAL FOCUS
1 new VITRE EXTENDS BASIC
1 new ADULT WATER RESCUE MANAKIN
1 new FLS ALL IN ONE TRAINER SYSTEM
1 new NEXUS SECURE TRANSACTION MGMT
1 new VIDEO URETERO RENOSCOPE
1 new PAVEMENT MARKING GARGAGE/ER-VALET-LOTS
1 new MRI PROJECT #15-002 BLDG IMPR
1 new E. MAIN PROJ #17-003 LEASEHOLD IMP
1 new EPIC PROJ. BLDG IMPR
1 new APPL& CERT. FOR LEEVER CLEAN RM
1 new LABOR/MATERIAL HR-PAYROLL RENOVATIONS
1 new E. MAIN PROJ #17-003 FIXED EQUIP.
1 new EPIC PROJ. CAPITAL LABOR
1 new TRANMISSION FOR HOSP TRUCK
1 new OVERBED TABLE
1 new VIDEO URETERO RENOSCOPE
1 new REMOVE/INSTALL STERILIZER/BOILER
1 new INST. INTERFACE VAI SQ INST MGMT
1 new TELESCOPE HOPKINS 11 0
1 new NETWORK UPGRADES PROCESSBY TRINITY
1 new MRI PROJ #15-002 FURNITURE/OFFICE EQUIPMENT
1 new E. MAIN PROJ #17-003 COMPUTERS
1 new E. MAIN PROJ $17-003 FURNITURE/OFFICE EQUIP
1 new EPIC PROJ. COMPUTER EQUIP
1 new EPIC PROJ FURNITURE/OFFICE EQUIP

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processed by St Francis	CIP project that was completed and moved to FA in FY17

User, OHCA

From: Cotto, Carmen
Sent: Friday, December 29, 2017 1:52 PM
To: Capone, Claudio
Cc: Roberts, Karen; User, OHCA
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Claudio,

A review of OHCA's compliance records indicated that due material related to Saint Mary's Docket Number 15-32045-CON Stipulation #12 has not been submitted to OHCA.

- Stipulation #12 states:

  "TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.
  In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

  a. *On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."*

Thirty date of the closing is August 31st, however, through previous email correspondence, dated May 25, May 16 and February 24, 2017, the Applicants and OHCA agreed that the material related to Condition #12 may instead be filed each November 30th. Therefore, the material is now overdue.

Please provide a response to the above CON compliance inquiry by January 12, 2017, two weeks from today. Please also remember to send to the OHCA general email inbox, which is OHCA@ct.gov , all material for the Docket. Please be assured that any material that will be received in the general inbox will become part of the public record for this docket number.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access

Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

User, OHCA

From: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Sent: Wednesday, January 17, 2018 2:11 PM
To: Cotto, Carmen
Cc: Roberts, Karen; User, OHCA
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Carmen…I will follow through on this and get an update.

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, January 17, 2018 2:03 PM
To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: [EXTERNAL] RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Hi Claudio,

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Thank you,
Carmen

Carmen Cotto, MBA
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P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

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From: Cotto, Carmen
Sent: Friday, December 29, 2017 1:52 PM
To: 'Capone, Claudio' <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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User, OHCA

From: Cotto, Carmen
Sent: Monday, January 22, 2018 10:04 AM
To: Lydia Shen; Roberts, Karen; User, OHCA
Cc: Capone, Claudio; Chris Hayes; Kyle Jurczyk; Keon Blackledge
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Follow Up Flag: Follow up
Flag Status: Completed

Hi Lydia,

We will let you know if we need anything else once the review of the documents is completed.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
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From: Lydia Shen [mailto:Lydia.Shen@TrinityHealthOfNE.Org]
Sent: Friday, January 19, 2018 2:20 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Chris Hayes <CHayes@Stmh.org>; Kyle Jurczyk <Kyle.Jurczyk@stmh.org>; Keon Blackledge <keon.blackledge@Stmh.org>
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hello Carmen,

Please find attached the requested information for Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

We apologize again for the delay. If you have any questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

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To: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: [EXTERNAL] RE: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Subject: RE: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Carmen,

I'm working with Claudio and the team at Saint Mary's to pull this information together. We anticipate submitting it by end of day tomorrow.

We apologize for the delay.

Regards,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

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W 860-714-6579

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Hartford, CT 06105

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From: "Cotto, Carmen" <Carmen.Cotto@ct.gov>
Date: January 17, 2018 at 2:02:50 PM EST
To: "Capone, Claudio" <Claudio.Capone@TrinityHealthOfNE.org>
Cc: "Roberts, Karen" <Karen.Roberts@ct.gov>, "User, OHCA" <OHCA@ct.gov>
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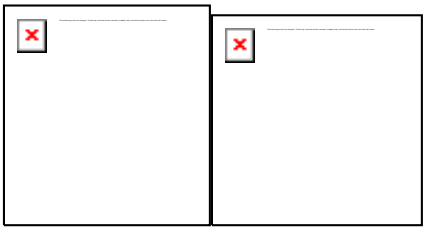
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



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User, OHCA

From: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Sent: Wednesday, January 31, 2018 11:54 AM
To: Cotto, Carmen; Roberts, Karen; User, OHCA
Cc: Capone, Claudio; Chris Hayes; Kyle Jurczyk; Natalie Cummings
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up
Attachments: Saint Mary's DN 15-32045 Reponse to Stipulation #12 - 01.31.2018.pdf

Good morning Carmen,

Attached, please find the information in response to the follow up question regarding Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

If you have additional questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, January 30, 2018 2:37 PM
To: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Subject: [EXTERNAL] FW: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Warning: This email originated from the Internet!

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Hi Lydia,

A review of the documents submitted to OHCA on January 19th related to Saint Mary's Docket Number 15-32045-CON Stipulation #12 indicates that it is missing information for FY 2017. The documents provided data

and related narratives for FY 2015 and FY 2016 Saint Mary's Community Benefits and Community Building Activities but not for FY 2017. Please provide the missing information.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

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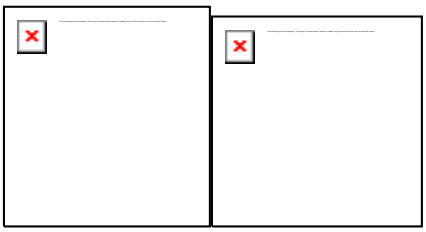

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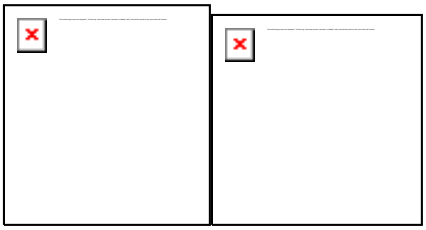

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Trinity Health
Of New England

January 31, 2018

Carmen Cotto
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: **Docket Number: 15-32045-CON** Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health Of New England

Dear Ms. Cotto,

Trinity Health Of New England is in the process of filing extensions for FY 2017 990s and they are due by August 15, 2018. The information needed to finalize all the community benefit questions is not yet available; therefore, we are unable to respond to Stipulation #12 with complete FY 2017 information. FY 2016 is the latest complete set of information available at this time and therefore was used in the Stipulation #12 response submitted January 19, 2018.

Please do not hesitate to contact me with any additional questions you may have.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

User, OHCA

From: Cotto, Carmen
Sent: Thursday, February 01, 2018 2:01 PM
To: Lydia Shen
Cc: Capone, Claudio; Roberts, Karen; User, OHCA
Subject: RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Hi Lydia,

We understand that the FY 2017 IRS 990s are yet to be finalized. However, Saint Mary's Docket Number 15-32045-CON Stipulation #12 does not require the Hospital to submit a finalized IRS 990 document.

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Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Lydia Shen [mailto:Lydia.Shen@TrinityHealthOfNE.Org]
Sent: Wednesday, January 31, 2018 11:54 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>

Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Chris Hayes <CHayes@Stmh.org>; Kyle Jurczyk <Kyle.Jurczyk@stmh.org>; Natalie Cummings <natalie.cummings@Stmh.org>
Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Good morning Carmen,

Attached, please find the information in response to the follow up question regarding Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

If you have additional questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

Trinity Health Of New England

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, January 30, 2018 2:37 PM
To: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Subject: [EXTERNAL] FW: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

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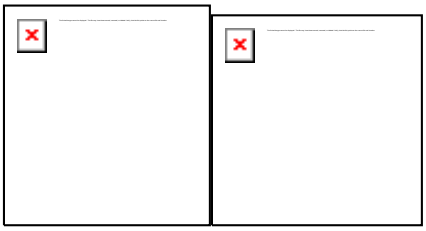

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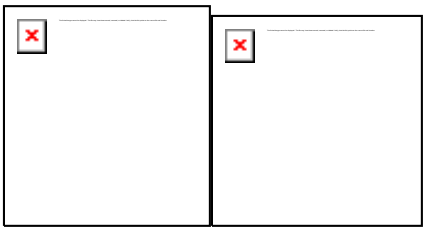

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Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

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Please let me know whether or not it does.

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User, OHCA

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Sent: Tuesday, February 13, 2018 10:51 AM
To: Capone, Claudio
Cc: Roberts, Karen; User, OHCA; Lydia Shen
Subject: RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

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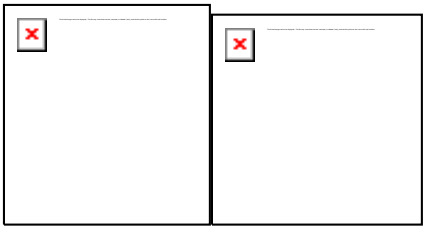

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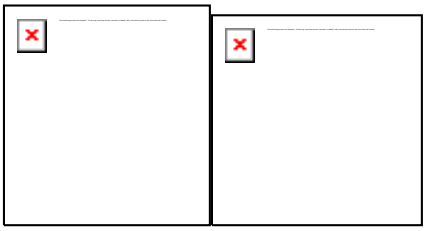

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, February 13, 2018 10:51 AM
To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>; Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Subject: [EXTERNAL] RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

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Hi Claudio,

Please provide us with the status of our request below.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Cotto, Carmen
Sent: Thursday, February 1, 2018 2:01 PM
To: 'Lydia Shen' <Lydia.Shen@TrinityHealthOfNE.Org>
Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Hi Lydia,

We understand that the FY 2017 IRS 990s are yet to be finalized. However, Saint Mary's Docket Number 15-32045-CON Stipulation #12 does not require the Hospital to submit a finalized IRS 990 document.

A document version of what was submitted for FY 2015 and 2016 to OHCA on January 19th that would show the Hospital's FY 2017 Community Benefits Programs and Buildings Activities dollars spent along with a narrative will be acceptable.

The Applicants and OHCA agreed that the material related to Stipulation #12 may be filed each November 30th. Therefore, the material is now overdue.

Please provide a response to the above CON compliance inquiry. Please also remember to send to the OHCA general email inbox, which is OHCA@ct.gov , all material for the Docket. Please be assured that any material that will be received in the general inbox will become part of the public record for this docket number.

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Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Good morning Carmen,

Attached, please find the information in response to the follow up question regarding Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

If you have additional questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

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Cc: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
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A review of the documents submitted to OHCA on January 19th related to Saint Mary's Docket Number 15-32045-CON Stipulation #12 indicates that it is missing information for FY 2017. The documents provided data

and related narratives for FY 2015 and FY 2016 Saint Mary's Community Benefits and Community Building Activities but not for FY 2017. Please provide the missing information.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,
Carmen

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Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hello Carmen,

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We apologize again for the delay. If you have any questions, please do not hesitate to reach out to us.

Thank you,
Lydia

Lydia Shen, MHA
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Subject: RE: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

Hi Carmen,

I'm working with Claudio and the team at Saint Mary's to pull this information together. We anticipate submitting it by end of day tomorrow.

We apologize for the delay.

Regards,
Lydia

Lydia Shen, MHA
Strategic Planner
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Of New England

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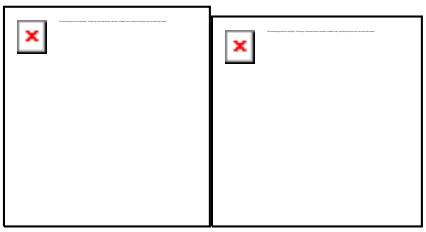

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Subject: RE: Saint Mary's, Docket number 15-32045-Stipulation #12

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? Stipulation #12 states:

"TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.
In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. *On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."*

Thirty date of the closing is August 31st, however, through previous email correspondence, dated May 25, May 16 and February 24, 2017, the Applicants and OHCA agreed that the material related to Condition #12 may instead be filed each November 30th. Therefore, the material is now overdue.

Please provide a response to the above CON compliance inquiry by January 12, 2017, two weeks from today. Please also remember to send to the OHCA general email inbox, which is OHCA@ct.gov , all material for the Docket. Please be assured that any material that will be received in the general inbox will become part of the public record for this docket number.

Thank you,
Carmen

Carmen Cotto, MBA

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Connecticut Department of Public Health
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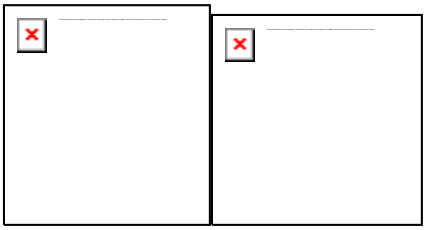

www.ct.gov/dph

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

NOTICE: This email and/or attachments may contain confidential or proprietary information which may be legally privileged. It is intended only for the named recipient(s). If an addressing or transmission error has misdirected this email, please notify the author by replying to this message. If you are not the named recipient, you are not authorized to use, disclose, distribute, make copies or print this email, and should immediately delete it from your computer system. Saint Francis Hospital and Medical Center has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

User, OHCA

From: Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Sent: Thursday, February 15, 2018 11:24 AM
To: Cotto, Carmen
Cc: Roberts, Karen; User, OHCA; Capone, Claudio
Subject: RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up
Attachments: Saint Mary's DN 15-32045 Reponse to Stipulation #12 - 02.15.2018.pdf

Good morning Carmen,

Attached, please find the requested information in response to Stipulation #12 for Saint Mary's Docket Number 15-32045 CON.

Please do not hesitate to reach out to us if you have any questions.

Thank you,
Lydia

Lydia Shen, MHA
Strategic Planner
Trinity Health Of New England

Lydia.Shen@TrinityHealthOfNE.org
W 860-714-6579

1000 Asylum Avenue
Hartford, CT 06105

TrinityHealthOfNE.org | Facebook | Twitter | Instagram

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Sent: Tuesday, February 13, 2018 1:51 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>; Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
Subject: RE: DRAFT Saint Mary's, Docket number 15-32045-Stipulation #12_follow up

Hi Carmen…I reached out to the Saint Mary's team and asked them to expedite their responses for us to submit to OHCA no later than Thursday morning.

I will notify you if anything changes.

Thanks,

Claudio

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, February 13, 2018 10:51 AM

To: Capone, Claudio <Claudio.Capone@TrinityHealthOfNE.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>; Lydia Shen <Lydia.Shen@TrinityHealthOfNE.Org>
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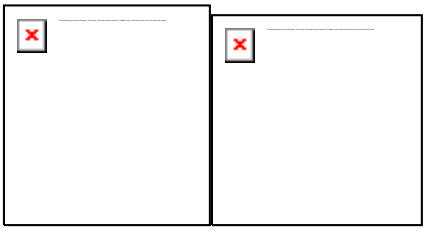

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than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.
In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

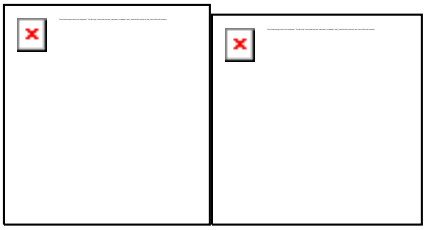
a. *On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."*

Thirty date of the closing is August 31st, however, through previous email correspondence, dated May 25, May 16 and February 24, 2017, the Applicants and OHCA agreed that the material related to Condition #12 may instead be filed each November 30th. Therefore, the material is now overdue.

Please provide a response to the above CON compliance inquiry by January 12, 2017, two weeks from today. Please also remember to send to the OHCA general email inbox, which is OHCA@ct.gov , all material for the Docket. Please be assured that any material that will be received in the general inbox will become part of the public record for this docket number.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

From: Claudio [mailto:claudiocapone@gmail.com]
Sent: Thursday, December 14, 2017 1:44 PM

To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: TH Of NE Combined Filing for CON Conditions

Hi Carmen...I hope this email reaches you in the preferred format.

Please let me know whether or not it does.

Thanks,

Claudio

NOTICE: This email and/or attachments may contain confidential or proprietary information which may be legally privileged. It is intended only for the named recipient(s). If an addressing or transmission error has misdirected this email, please notify the author by replying to this message. If you are not the named recipient, you are not authorized to use, disclose, distribute, make copies or print this email, and should immediately delete it from your computer system. Saint Francis Hospital and Medical Center has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

Trinity Health
Of New England

February 15, 2018

Carmen Cotto
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: **Docket Number: 15-32045-CON** Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health Of New England

Dear Ms. Cotto,

Please see the attached document in satisfaction of Stipulation 12 of the above-referenced Agreed Settlement Order dated August 1, 2016. We revised our January 19, 2018, submission to include preliminary FY 2017 information.

Please do not hesitate to contact me with any additional questions you may have.

Sincerely,

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

For Saint Mary's Hospital (Docket#15-32045)

Condition #12 – TH-NE shall maintain community benefit programs and community building activities for the Hospital for three (3) years after the closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years towards the Hospital's community building activities in terms of dollars spent.

In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. **On an annual basis, TH-NE shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the Hospital's website.**

Community Benefit Programs

In FY 2016, Saint Mary's Net Community Benefit was $29,494,286. In contrast, the FY 2017 preliminary Net Community Benefit was $31,693,646 (FY 2017 IRS990 filing will be fully available and finalized on August 15, 2018).

Form 990, Schedule H, Financial Assistance, Net Benefit	FY 2015	FY 2016	FY 2017
Financial Assistance at cost	$ 1,071,892	$ 2,206,026	$ 1,234,863
Medicaid	$ 18,934,819	$ 20,475,484	$ 25,369,239
Cost of other means-tested government programs			
Total Financial Assistance	$ 20,006,711	$ 22,681,510	$ 26,604,102
Other Benefits			
Community health improvement services and community benefit operations	$ 200,781	$ 225,257	$ 136,274
Health professions education	$ 4,976,835	$ 5,401,397	$ 4,813,527
Subsidized health services	$ 2,439,103	$ 1,113,750	$ -
Research			
Cash and in-kind contributions for community benefit	$ 76,697	$ 72,372	$ 139,743
Total Other Benefits	$ 7,693,416	$ 6,812,776	$ 5,089,544
Total	$ 27,700,127	$ 29,494,286	$ 31,693,646

Based on results of the 2016 CHNA, the five selected priorities are access to care; mental health and substance abuse; chronic disease; tobacco use and asthma; and health communications. The following community benefits and community building describe how hospital investments and support are being applied towards CHNA and population health management objectives.

An example of one of Saint Mary's many community benefit services include the Early Detection and WISEWOMAN Program for Breast, Cervical, and Colorectal Cancer. As the only hospital in Waterbury offering this program, it has assisted and screened more than 3,200 uninsured or underinsured women and men since the program began in 1995. Patients receive free screening and diagnostic services and work directly with a nurse case manager to address barriers to care if faced with a high risk or cancer

diagnosis. To date, over 75 women have been diagnosed with breast or cervical cancer through our program. These women have received appropriate and timely follow-up care and treatment. After over two decades of service, the early detection program continues to impact the lives of women and their families. The program is offered through the Saint Mary's Family Health Center.

Other examples of Saint Mary's community benefit programs and services include support groups that are hosted and supported by the hospital. The Bariatric Support Group at Saint Mary's is held on a monthly basis and typically assists 40 patients per month to provide professional, compassionate support after weight loss surgery.

In addition, Saint Mary's has joined the Spirit of Women network, a national organization which engages, educates, and motivates women to take action for better health for themselves and their families through inspiring experiences, events, and healthcare communications. Since the program's inception in 2015, more than 2,000 women attended 13 events that were held at local community venues. These programming and health initiatives directly relate back to the CHNA priority areas specific to chronic disease and health communications.

One program, "Hoop to Help", has had an incredible impact. In 2015, a Saint Mary's colleague saw a need in the Waterbury community. Through the Community Tabernacle Outreach Center, the colleague founded and organized the annual Hoop to Help Basketball Tournament at the Waterbury Police Activity League and Johnathan Reed Elementary School. The tournament serves as an outreach effort to provide Waterbury Public School students with back-to-school supplies.

Inspired by the colleague's efforts, in 2017, Saint Mary's stepped in to assist with the tournament. Saint Mary's saw it as an opportunity to make a difference in the lives of local students by providing necessary school supplies as well as to encourage physical activity. Over 25 teams from Waterbury and surrounding towns attended the tournament in late July and raised money towards the program. In addition, during the course of the tournament Saint Mary's Hospital was able to offer health and wellness information and provide first-aid materials.

The colleague stated that, "because of Saint Mary's involvement in the tournament, the Community Tabernacle Outreach Center was able to almost double what was given in previous years." Over 1,000 students in the Waterbury Public School system received backpacks filled with school supplies within the first month of the school year.

The Hoop to Help Basketball Tournament is just one example of how Saint Mary's Hospital is living the mission of being a transforming healing presence within the communities it serves.

Saint Mary's is also developing a Community Care Team (CCT). A Community Care Team is an innovative program developed to provide a collaborative model of care for complicated patients through multiagency partnerships. CCTs consist of a team of hospital staff and community agencies who focus on the medical and social needs of a shared population. The identified patients are those who may not have responded to a traditional approach and who are likely to have improved outcomes as a result of enhanced care coordination.

In Connecticut, CCTs are showing a promise in their ability to impact outcomes for both the individual and the hospital. The Greater Waterbury area is one of the few major markets in Connecticut without a Community Care Team program. This CCT would be brought forth with the assist of community

agencies and Greater Waterbury Health Improvement Partnership. The creation of this CCT will directly align with the access to care, and mental health and substance abuse priority areas for the Greater Waterbury Health Improvement Partnership CHNA.

In addition to these programs, Saint Mary's also has successful partnerships with other community organizations such as the Greater Waterbury United Way, Wellmore Behavioral Health for Children and Families, and the Morris Foundation, which offers treatment, prevention, education, and recovery support for individuals with substance abuse and behavioral health issues. The hospital has also forged collaborations to bring world-class healthcare services to the community through The Harold Leever Regional Cancer Center, a freestanding 40,000-square-foot facility dedicated to outpatient cancer care, which is a joint venture partnership between Saint Mary's Hospital and Waterbury Hospital, extending its reach.

In addition to the community building activities identified and the quantified free or discounted health services identified in the reported charity care figures, SMH provides other community benefits. Examples include screenings, lectures, health fairs, support groups, consultations, referrals to outside agencies and others.

Health professions education:

SMH is a teaching hospital and is committed to preparing future healthcare professionals. This category represents that majority of Saint Mary's community benefit activities and includes efforts to generate interest in health professions as well as providing a clinical site for medical students, high school students and colleges for students who are pursuing degrees as nurses, physician assistants (PA), occupational, speech and physical therapists, radiology technologists and more.

Subsidized Services:

Saint Mary's Hospital provides health services to patients with no insurance or state insurance including emergency services and behavioral health clinics.

Financial and In-kind Contributions:

Saint Mary's Hospital financially supports other community organizations through sponsorships and in-kind donations via time spent by staff in the community on local boards and volunteering time for local organizations.

Community Benefit Operations:

The costs associated with planning and operating community benefit programs are in itself a benefit to the community. This category also includes costs associated with conducting a Community Health Needs Assessment as well as developing an implementation strategy.

Free Care

Free care is also provided for uninsured individuals whose income is below 200% of the Federal Poverty Income Levels. For self-pay accounts whose income are between 200% and 400% of the Federal Poverty Income Levels, Saint Mary's will reduce their bill by sliding scale discount for an

additional charity care reduction of 25% off of their remaining account(s) balance(s) for a total discount of up to 65%.

Community Building Activities

Saint Mary's FY 2016 Net Community Building Activities was $179,742. Preliminary FY 2017 numbers indicate a decrease from FY 2016. Most of the decrease was in "Coalition Building" which was a result of several unexpected shifts in leadership and positions within Saint Mary's who were directly involved with Community Building Activities. We anticipate an increase in Community Building Activities in FY 2018 as Saint Mary's increases its representation and involvement with community coalitions that address economic revitalization and need for affordable housing.

Form 990, Schedule H, Community Building Activities, Net Benefit	FY 2015	FY 2016	FY 2017
Physical improvements and housing	$ 202	$ 403	$ 1,772
Economic development			
Community support		$ 13,032	$ 15,639
Environmental improvements			
Leadership development and training for community members			
Coalition building		$ 13,357	$ 7,662
Community health improvement advocacy			
Workforce development	$ 169,504	$ 152,950	$ 150,715
Other			
Total	$ 169,706	$ 179,742	$ 175,788

Saint Mary's Community Building Activities include some of the following: emergency preparedness, board support for organizations that address specific social problems such as poverty, homelessness, and environmental issues, including Greater Waterbury Health Improvement Partnership (GWHIP), workforce development and recruiting to minorities and diverse languages, participation in several Connecticut Hospital Association (CHA) collaborative efforts, United Way of Greater Waterbury Day of Action, and public community landscaping.